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Characterizing Reflective Practice in Psychotherapists' Practice and its Relationship with Experiential Avoidance

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CHARACTERIZING REFLECTIVE PRACTICE IN PSYCHOTHERAPISTS' PRACTICE AND ITS RELATIONSHIP WITH EXPERIENTIAL AVOIDANCE

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Abstract

Reflective practice (RP) is an essential element of all professional work, including psychotherapy. However, RP can also cause feelings of anxiety and discomfort that may be barriers to engaging in RP. This research aimed to 1) describe the relationship between RP and experiential avoidance in a sample of independent licensed psychotherapists, 2) explore among psychotherapists the previous finding among physicians that greater years of practice (YOP) and age predict lower levels of RP (Mamede & Schmidt, 2005), and 3) describe reported barriers to and supports of engaging in RP. An online survey was used to collect data and 54 participants were included in analyses. The sample was divided into low and high RP groups using a median split and group differences were analyzed. Results indicated a significant difference in the Repression and Denial subscale of the Multidimensional Experiential Avoidance Questionnaire between groups. When only institution-based participants were examined, the Distress Aversion (MEAQDA) mean score was also significantly different. In this sample, RP was positively and significantly correlated with both age and years of practice. Participants identified a range of barriers to engaging in RP as well as variables that support RP. These results suggest directions for future research and practice recommendations that could increase engagement in RP.

keywords: reflective practice, reflection, experiential avoidance, psychotherapy practice

Introduction

Psychotherapists have the opportunity to help clients make meaningful change in their lives. Although this can make psychotherapy a highly rewarding professional career, it can also require much of practitioners. Over the span of their career, psychotherapists are expected to respond to a range of often competing demands, such as continuously replenishing their personal reserves, developing and advancing their psychotherapy skills (e.g., continuing development, professional development), and staying abreast of current research. Much attention has been given to supporting psychotherapists during training to develop the skills to sustain a long-term psychotherapy career, including skills to maintain their personal reserves (e.g., self-care) and continue the development of expertise (APA, 2006). Relatively little research has addressed the maintenance and continuing development of the same skills among psychotherapists post-formal training.

Continuing development, in particular, is a well-recognized element of professional practice. Despite the relative lack of research concerning continuing development (e.g., operationalization, assessment), many licensing boards require evidence of continuing education (e.g., Continuing Education credits required by the Massachusetts Board of Registration of Psychologists; Rules and Regulations Governing Psychologists, 2014). Continuing Education credits generally represent participation in courses aimed at presenting new research, theoretical approaches, or clinical interventions (Rules and Regulations Governing Psychologists, 2014).

Such learning is only one aspect of continuing development; reflective practice (RP) is another. RP is thought to play a key role in learning, particularly learning that

extends beyond memorization of facts to the complex application of information (for a sample of theories see Boud & Walker, 1998; Johns, 1995). In addition, RP can help psychotherapists bring focused attention to difficult aspects of their practice, develop a more complex understanding of themselves and how they practice, and maximize their flexibility (e.g., Gustafsson & Fagerberg, 2004; Haarhoff, Gibson, & Flett, 2011) in responding to differences among clients.

Yet RP can also cause negative reactions (Knight, Sperlinger, & Maltby, 2010; Platzer, Blake, & Ashford, 2000; Vachon & LeBlanc 2011), which may be barriers to effective RP. Some psychotherapists may experience anxiety about discovering something undesirable about themselves, discomfort with the feelings of vulnerability, and an increased pressure to make difficult changes to their practice (e.g., Platzer et al., 2000; Vachon & LeBlanc, 2011). This anxiety may interfere with psychotherapists' willingness to engage in RP.

The lack of engagement in RP may represent an instance of experiential avoidance (EA), which is known to be associated with decreased functionality (e.g., avoiding potentially distressing but important situations like a job interview) and a wide range of psychiatric difficulties (for a summary of studies see Hayes, 2017, November). This project aimed to 1) explore the relationship between RP and EA in a sample of independent licensed psychotherapists, 2) replicate, among this sample, the previous finding that, among physicians, greater years of practice (YOP) and age predict lower levels of RP (Mamede & Schmidt, 2005), and 3) characterize RP among this population.

Background

Reflective Practice

Reflective practice (RP) has been conceptualized as an essential component of professional and competent practice in psychology, as well as other professional fields (e.g., counseling, see Irving & Williams, 1995, business, see Keevers & Treleaven, 2011, human resources, see Preskill, 1996, and mediation, see Stains, 2012). Prior to the 1980s, professionalism was generally characterized by 'technical rationality' - the application of specialized training in a linear, problem-solving fashion (Bogo, Regehr, Katz, Logie, & Mylopoulos, 2011). From this perspective, professionals are supposed to approach situations as though they were equations; once the problem is identified, then the appropriate solution can be applied. Thus, the purpose of training is to instill sufficient understanding of a wide range of situations (i.e., formulae), methodology for identifying the appropriate solution, and a range of effective solutions.

In the 1980s, Donald Schön believed that the knowledge taught and valued by academia was incongruent with the competence that was needed within professional practice. In addition, he noted that the competence needed in professional practice was not as well articulated or understood as the academic knowledge (Schön, 1983). Thus, in 1983, he re-characterized professionalism; he articulated a process-based model that highlighted RP as the key to professional and competent practice. Based on his theories, observations of professionals, and the state of training and research at that time, Schön suggested that more attention should be given to the process through which professionals apply knowledge and use it to guide their actions. He argued that the cultivation of RP is an important method for bridging the gap between academic knowledge and professional

practice (e.g., integration of clinical research and clinical practice; Schön, 1983).

Since then, RP has become a generally accepted meta-competency in professional practice (Cheetham & Chivers, 1998). Meta-competencies are non-specific skills that are believed to be essential in professional practice across fields (Cheetham & Chivers, 1998). For example, critical thinking is a commonly recognized meta-competency that supports professionals' ability to learn how to make sense of a complex set of symptoms, navigate ethical conflicts, and adhere to a code of conduct. Meta-competencies represent a higher level of cognitive organization and skill, and usually require more active learning, as compared to competencies that can be learned by rote (e.g., a company's ethical guidelines; Cheetham & Chivers, 1998). In addition, meta-competencies often play a key role in learning and developing other competencies and skills (Bogo et al., 2011; Cheetham & Chivers, 1998).

Consequently, a lack of RP may interfere with the acquisition of necessary skills. For example, Argyris (1976) theorized that RP allows professionals to build on their knowledge of how to do something and consider *why*. Aukes and colleagues (2007) argued that RP is important for the analytical thinking required by complex clinical cases. Boud and Walker (1998) asserted that RP supports bridging classroom knowledge and field experience to create a coherent training experience. Furthermore, there may be specific risks for health professionals associated with ineffective or avoidance of RP. Page (2003) discussed palliative care practitioners' emotional burden and that some professionals protect themselves by removing a patient's individual identity. Page (2003) argued that this de-individualization interferes with patient care as it diminishes RP. Page notes that diminished RP could make it more difficult to account for all important

elements in a clinical situation resulting in the increased risk that practitioners may increase a patient's pain through thoughtless action (2003). In summary, RP, as a meta-competency, plays an important role in helping professionals acquire professional skills, practice professionally, and, particularly within the health professions, maintain a high quality of patient care.

As research and training programs have identified and more clearly articulated professional competencies and meta-competencies, there has been a simultaneous movement demanding accountability in health professions to ensure the safety of consumers and professionalism of clinical psychologists (American Psychological Association, 2006). In 2004, the APA formed a task force charged with identifying those competencies essential to the professional and competent practice of clinical psychology. The task force divided professional clinical psychology competencies into several areas: professionalism, relational, science, application, education, and systems. Included in under the 'professionalism' heading is a sub-category of 'RP.' However, the task force specifically avoided defining RP because of the risk of irreconcilable disagreement amongst psychologists of varying orientations, training traditions, and specialties. Instead, the task force identified behavioral anchors (i.e., benchmarks) for each competency at each stage of training (Table 1).

Although these benchmarks represent a meaningful move towards fostering competent and professional practice among psychologists and the task force explicitly states that competency should be assessed past formal training years, the benchmarks do not extend beyond the evaluation of 'readiness for entry to practice.' In the APA report (2006), the authors note that the assessment of competence during training is relatively

easily accomplished because of the high level of oversight and supervision during training. In contrast, assessment of competency after formal training is much more difficult to accomplish.

Table 1

APA Competency Benchmarks for Reflective Practice

Reflective Practice: Practice conducted with personal and professional self-awareness and reflection.

Readiness for Practicum	**Readiness for Internship**	**Readiness for Entry to Practice**
Displays basic mindfulness and self-awareness; engages in reflection regarding professional practice	Displays broadened self-awareness; utilizes self-monitoring; engages in reflection regarding professional practice; uses resources to enhance reflectivity	Demonstrates reflectivity both during and after professional activity; acts upon reflection; uses self as a therapeutic tool

Source: APA Competency Benchmarks, 2006

The APA Competencies Task Force noted that several professions and countries currently attempt to assess competency post degree. For example, The College of Psychologists of British Columbia's (CPBC; the regulatory body for psychologists in British Columbia, Canada) Continuing Competency Program requires, among other elements, documentation of eleven hours of self-study and twelve hours of structured interactive activities (CPBC, 2012). Part of the intent of the "self-study" component is to consider how the information discovered through self-study affects clinical psychology practice. In the structured interactive activities, clinical psychologists are expected to meet regularly with a group of colleagues, learn from each other, use each other as sources of new ideas and feedback, and consider together how to incorporate new knowledge and feedback into their practice (CPBC, 2012). There are no such requirements in any licensure renewal procedures for clinical psychologist in any state of

the U.S.A.

There are several factors that contribute to this, the discussion of which is beyond the scope of this document. Many of the barriers are due to the wide range of orientations and beliefs which psychotherapists hold. This plethora of beliefs is difficult to reconcile into a single theory of what psychotherapy practice should and should not include. A clearly articulated definition that is widely accepted is equally difficult to develop and, without it, it is difficult to develop standardized assessments and conduct generalizable research.

The development of such a definition of RP is also impeded by a mixed terminology (D'Cruz, Gillingham, & Melendez, 2007). Several terms are used interchangeably, and, simultaneously, these terms can refer to distinct concepts. Such terms include, but are not limited to, self-reflection, reflexivity, reflectivity, and self-exploration. D'Cruz and colleagues (2007) reviewed definitions for 'reflexivity' and its associated terms, 'reflectivity' and 'critical reflection,' in the nursing literature. They presented three categories of definitions, or "variations." The first variation consists of definitions that refer to the practice of exploring one's response to one's situation. In this variation, reflexivity describes an exploration of personal choices and the possibility of change. The second variation refers to reflexivity as a professional endeavor in which knowledge itself is explored (D'Cruz et al., 2007). Specifically, in this variation reflexivity explores how knowledge is generated and how power relations influence this process. In the exploration of knowledge generation, professionals explore their own biases and assumptions and examine how these influence their understanding of a situation. The third variation of definition is an extension of the second, in which the

impact of emotion on the process of knowledge generation is examined. This includes both how emotions affect thought, how thought affects emotion, and the role of these processes in meaning making and practice (D'Cruz et al., 2007).

Although psychology has yet to agree on a basic definition of RP, many of the definitions share certain features. This is likely because most modern definitions are based on John Dewey's (1910) early writing and Donald Schön's (1983) later articulation of RP as an important element of professionalism. Although their definitions and models have been expanded and built upon extensively since then, the basic conceptualization of RP has remained relatively unchanged and is reflected in elements that are common in most definitions. In the early 20th century, John Dewey (1910) posited that RP is the process through which professionals become aware of their 'implicit knowledge base,' meaning those schemata that guide behavior but of which we are not aware. Dewey argued that the development of schemata about how the world works is an automated and innate process (Dewey, 1910). Thus, the primary purpose of education is to develop people's ability to build useful schemata, rather than instill facts or teach someone how to memorize material. Dewey (1910) conceptualized reflective thinking as the process by which people can observe their thinking and consciously develop their thinking processes.

Schön suggested several forms of RP, including reflection-in-action and reflection-on-action (Schön, 1983). 'Reflection-in-action' is the process by which people pay attention to several elements of the present moment including: the context, the task, and their emotional state and activated biases. 'Reflection-on-action' is the process by which people consider their past actions and make meaning of those actions, particularly

as they relate to the present moment and future tasks (Schön, 1983). Schön also articulated 'reflection-on-self' as the process by which people look inward and observe their own meaning-making structures (Schön, 1983).

The American Psychological Association (APA) recognizes a broad and non-specific conceptualization of RP via behavioral correlates. In their 2006 final report, the APA competencies task force developed a series of benchmarks by which to determine trainees' readiness for each level of clinical training. One of the categories, entitled "Reflective Practice/Self-Assessment/Self-Care," asserts that trainees should demonstrate "practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care" (APA competencies task force, 2006; Table 1). As noted earlier, the task force chose not to develop a definition of RP because of the enormity of the task, rather they developed behavioral markers to gauge level of RP. Although the behavioral markers are also somewhat vague, the inclusion of this benchmark underscores the importance of RP among clinical psychologists.

Not surprisingly, the variety of definitions is reflected in a lack of unity in how RP is studied. The current body of empirical literature is generally limited to self-report measures and investigations of the usefulness and feasibility of methods for engaging in RP. For example, Ferreira, Basseches, and Vasco (2017) integrated two existing models of psychotherapeutic change, phase-by-phase and moment-by-moment, to create a general framework for RP to increase psychotherapeutic effectiveness. They note that change occurs in phases that are important to identify such that psychotherapy is attuned to the appropriate stage (e.g., fostering initial hope and working alliance vs. recognizing personal agency). In addition, there are changes that occur in the moment-by-moment

that are equally as essential to have in awareness in order to appropriately attune psychotherapy (e.g., whether clients require a holding environment vs. reinterpretation of experiences). They provided a series of questions meant to promote RP, specifically framed by this model of psychotherapeutic change (Ferreira et al., 2017).

Some researchers drew from the theoretical literature focused on what constitutes RP to develop measures. For example, Mamede and Schmidt (2004) developed a self-report measure and tested the fit of an a priori five-factor model. They found that the data fit their model and indicate five RP behavioral sets that include 1) deliberate induction, 2) deliberate deduction, 3) testing and synthesizing, 4) openness to reflection, and 5) meta-reasoning. Other researchers, particularly those exploring the viability of methods for engaging in RP (e.g., online diaries, critical incident analysis), focus on the extent to which participants engaged in RP (and their reactions to the process), rather than the content or degree of reflection (e.g., Dornan, Carroll, & Parboosingh, 2002; Knight et al., 2010; Platzer et al., 2000; Vachon & Leblanc, 2011). Qualitative analyses have broadly investigated participants' reported experiences with RP but often do not gather related information such as the frequency and content of the reflection (e.g., Fisher et al., 2015; Salter & Rhodes, 2018).

Understanding the implementation of RP is complicated by the structure imposed by the clinical setting. In many clinical settings, psychotherapists' use of time is significantly impacted by institutional regulations and requirements (e.g., billing practices for managed healthcare). Unfortunately, most forms of reflection are not covered by health insurance. Nonetheless, most clinical settings have some standard requirements that require psychotherapists to reflect on case conceptualization and treatment planning

(e.g., team meetings and case conferences) to improve patient care. Although, these activities do not often ask practitioners to reflect on their own role in psychotherapy, they offer an opportunity to discuss and find support around difficult cases that may be experienced as challenging or emotionally activating. Independent psychotherapists may also elect to participate in consultation groups or seek professional supervision that similarly aim to improve practice through the provision of multiple perspectives on cases, emotional and professional support, and a venue for examining oneself as a psychotherapeutic tool. Although there are some supports available for some aspects of RP, there may be barriers to effective RP that are unaddressed by these supports.

Research delineating whether and how psychotherapists engage in RP is limited, as is research identifying potential barriers and facilitators. In addition to the strong theoretical argument for the essential role of RP in professional and, more specifically, psychotherapy practice, there is growing evidence that psychotherapists benefit from engagement in RP and that its integration into practice is a marker of increasing maturity and experience. Fisher et al. (2015) interviewed six clinical psychologists in Singapore regarding their experiences with RP. Participants reported several benefits to their engagement in RP, including, but not limited to, self-understanding and how they impact psychotherapy, increased engagement with clients, increased clarity in complex or "stuck" cases, and better integration of ethics and professional standards in their daily work (Fisher et al., 2015).

Cognitive-Behavioral Therapy (CBT) training often includes a self-practice element. Generally, practitioners are expected apply CBT concepts to themselves in somewhat formal and semi-structured formats (e.g., workbooks, reflective blogs; Davis,

Thwaites, Freeston, & Bennett-Levy, 2013). In a study that invited experienced CBT psychotherapists to engage in a 10-week self-practice workbook, participants that completed the full intervention experienced statistically significant increases in their perceived ability in both cognitive therapy (i.e., technical skills) and empathy skills.

The importance of RP in clinical practice is further highlighted by psychotherapists' reflections on how they have matured with experience. Salter and Rhodes (2018) interviewed eleven clinical psychologists in Australia and invited them to reflect on their personal-professional development. Participants noted three core themes of development. These themes appeared to result from their reflection on their work and personal factors and their choices to change their practice so that work and personal factors were more aligned. The themes were 1) practicing from an orientation/model of practice that resonated with their personal values, 2) fostering personal genuineness in the therapy room such that there was no longer a distinctly different "therapist persona," and 3) using their own internal reactions to inform the psychotherapy (Salter & Rhodes, 2018).

Investigations from clinical training for psychotherapists and other areas of healthcare can provide addition meaningful information and potential avenues of exploration (e.g., medicine, social work, and nursing). As noted previously, RP in training of clinical psychologists has received much more attention in the literature than RP among post-training psychologists. Although a complete review is beyond the scope of this project, it is worth considering a few examples as they can inform the current investigation.

Similar to the literature related to post-training psychologists, there is a

considerable amount of literature developing theories of training and supervision to increase RP. Wong-Wylie (2007) interviewed five doctoral level counseling trainees in Canada about the barriers and facilitators to RP after they experienced critical incidents. The author's analysis articulated factors related to having a safe and reflective environment and relationships (both peer and supervisory), engaging in specifically reflective tasks, and trusting oneself as facilitating RP. Several factors were identified as barriers to RP, all were generally related to unsafe and non-reflective environments and relationships (both peer and supervisory; Wong-Wylie, 2007).

In a survey of supervisors and supervisees in Australia, Calvert, Crowe, and Greyner (2016) identified currently employed strategies for increasing RP through supervision. There was agreement between supervisors and supervisors that Socratic questioning was the most frequently used method for fostering RP. Supervisees reported it as the most helpful method, from a wide range of methods (e.g., journaling, supervisor modeling, reviewing session videos). In contrast, supervisors reported that sharing their thought processes aloud was the most useful strategy. Interestingly, supervisors considered the reflexive dialogue/Socratic questioning methods as an integral aspect of supervision practice; however, supervisees noted that it was primarily related to effectiveness of the working alliance (Calvert et al., 2016). Again, interpersonal and relational aspects of supervision were highlighted as important for facilitating RP.

There is some empirical evidence that psychotherapists' understanding of and perceived ability to engage in RP can be increased. Cooper and Wieckowski (2017) developed and administered a structured reflective practice worksheet to a sample of clinical psychology doctoral program students. They also delivered didactics and

educational materials about RP prior to administration of the worksheet. Significantly more participants perceived themselves as knowledgeable about RP and more capable of engaging in RP (Cooper & Wieckowski, 2017).

Models of supervision that specifically promote RP tend to focus on the dynamic interplay between technical skills, clinical and educational settings, and supervisory relationships and structure. For example, Curtis, Elkins, Duran, and Venta (2016) presented a model they title Vertical Supervision as specifically aimed to promote RP and clinician self-efficacy. The model incorporates several levels of supervision, including peer, group, and individual between and among trainees and supervisors at varying levels. In the context of this relatively high level of contact, several processes to promote RP are regularly integrated into interactions, including supervisor modelling, reviewing videos of supervisors' therapy sessions, prompting supervisees to engage in RP, and encouraging supervisees to model RP with in their other interactions (Curtis et al., 2016). The authors note that this level of interaction and focus on RP is aimed at developing a *milieu* of RP.

The British Psychological Society (BPS) explicitly promotes RP as an essential element of practice for clinical psychologists. This tenant supports the additional practice guideline of Continuing Practice Development (CPD). This includes "reflective, outcome-based approach which focuses on the learning gained from CPD and its application to current or future practice" (BPS, 2017, p. 14). Based on a broad review of models aimed at supporting PPD (an earlier iteration of practice codes related to RP), Sheikh et al. (2007) presented a circumflex model in which the main processes of PPD, namely self-awareness, resilience, and professional effectiveness, are continuously fostered and developed through layers of practice. These layers include internal learning

processes, behaviors that aid awareness and reflection, psychologists' relationships and the systems in which they exist, and the broader role of courses, workshops, and other discrete tasks (Sheikh et al., 2007). This highly complex model is instructive in its recognition that PPD and, relatedly, RP are integrally connected with all aspects of professional and personal functioning.

Among physicians, there are several studies aimed at evaluating the usefulness of narrative inquiry, which is a common practice to increase RP among residents, and theoretical and opinion pieces addressing the importance and integration of RP into medical training. Similar to psychotherapy, there is more limited research on the role of RP among post-training physicians. Mamede and Schmidt (2005) investigated correlates of RP among primary care physicians. Of primary interest here, they found that RP was negatively correlated with age and years of practice. Physicians who reported practicing primarily in hospitals reported more time engaged in RP than those who primarily practiced in private settings. Specialty physicians also reported more time spent in RP (Mamede & Schmidt, 2005). They posited that over time and in the face of systemic demands (e.g., client loads, expediency), physicians may become complacent. Mamede and Schmidt (2005) also theorized that the differences found between workplaces may be due to systemic factors in which physicians at hospitals are subject to higher standards of care and greater levels of oversight than those in specialty clinics.

Reporting on a trial of an online diary to support RP among physicians, Dornan and colleagues (2002) noted that many participants reported liking the diary format but did not utilize it much. The participants reported that their primary barriers were a lack of a designated time for RP in their professional setting and difficulty rearranging their

schedule to make that time. Participants also noted some negative emotions that impeded their use of the diary. These negative emotions were reportedly related to difficulty with the technical aspects of the diary, lack of time, and low institutional support for using the diary (Dornan et al., 2002).

RP can also be associated with negative feelings, such as anxiety, distress, and a sense of failure. Vachon and LeBlanc (2011) asked a group of occupational therapists to reflect on their experience while analyzing a current and a past critical incident. Participants reported significantly more negative emotions in response to analyzing past critical incidents (analyzing current critical incidents was seen as good clinical practice). These negative emotions included dissatisfaction with oneself and a sense of failure and powerlessness which the participants struggled to accept and integrate (Vachon & LeBlanc, 2011).

In 2010, Knight and colleagues ran a series of RP groups for clinical psychology trainees. The participants were asked to rate their subjective distress related to participation in the groups. Forty-three percent of participants rated the groups as highly distressing. Platzer et al. ran RP groups with nurses and then conducted qualitative interviews. Of relevance to the present discussion, many participants reported a reluctance to explore areas in which they were insecure not because of the potential judgment or criticism of others, but the desire to avoid thinking of themselves in a negative light. Interestingly, many participants also reported that their primary training had focused on the accumulation of facts and, thus, the process of reflective learning was uncomfortable and, at times, distressing (Platzer et al., 2000).

In summary, RP is generally accepted as an essential element of professional

practice, applying classroom training and research in a clinical setting, and, more specifically, psychotherapeutic practice. There are benefits associated with regular engagement in RP, such as more effective translation of academic knowledge to clinical practice. In addition, the literature has also identified meaningful risks associated with a lack of RP, such as increased risk of thoughtless and potentially harmful action. Despite these benefits and risks, research has yet to examine factors that may impede RP among psychotherapists. As anxiety and emotional distress are common and usually unwanted accompaniments to RP, it is possible that they also serve as impediments to engagement in RP.

Experiential Avoidance

Engagement in reflective practice (RP) may produce anxiety which could lead to behavioral reactions that serve as barriers to effective RP. In the Acceptance and Commitment Therapy (ACT) tradition, experiential avoidance (EA) is defined as an individual's discomfort experiencing certain internal events (e.g., sadness, anxiety, specific memories), which leads to efforts to change, control, or escape these experiences (Hayes, Strosahl, & Wilson, 1999). It is important to note that from this perspective, it is not the internal experiences but the stance of non-acceptance toward the internal experiences that constitutes the drive to avoid (e.g., EA). This stance of non-acceptance can be expressed in many ways that include behavioral, emotional, and cognitive elements. Just as all people experience anxiety and other internal experiences, EA is considered a normative human process. As described previously, most people will experience some form of anxiety due to anticipation of and engagement in RP. Given that psychotherapists are human, it is reasonable to conclude that they are equally as likely to

engage in EA as anyone else. While there is no current research specifically focused on the relationship between EA and RP, it is reasonable to draw conclusions from the existing literature about how EA may affect psychotherapists and the impact on RP.

Multiple studies have found that EA is associated with a wide range of psychopathologies, as well as more specific anxiety- and depression-related behaviors. The bulk of the literature focuses on mood and anxiety disorders, for example, Generalized Anxiety Disorder (non-clinical population, see Buhr & Dugas, 2009, 2012; clinical populations, see Lee, Orsillo, Roemer, & Allen, 2010; Roemer, Orsillo, Salters-Pedneault, 2008), chronic depression (see Barnhofer, Brennan, Crane, Duggan, & Williams, 2014), Obsessive Compulsive Disorder (see Twohig, Hayes, & Masuda, 2006a), depression (see Leahy, Tirch, & Melwani, 2012), social anxiety disorder (see Niles et al., 2014), hoarding (Ayers et al., 2014; Wheaton, Fabricant, Berman, & Abramowitz, 2013), and skin-picking (Flessner & Woods, 2006; Twohig, Hayes, & Masuda, 2006b). EA has also been found to play a role in many other disorders, such as alcohol abuse and dependence (Levin, Lillis, Seeley, & Hayes, 2012) and schizophrenia and psychotic disorders (O'Driscoll, Laing, & Mason, 2014; Valiente et al., 2011). In addition to the role of EA in clinical disorders, research has also found an association between EA and a general sense of well-being. Karekla & Panayiotou (2011) found that higher levels of experiential avoidance predicted greater self-reported levels of psychological distress and lower levels of well-being in a non-clinical sample of adults.

In ACT, one of the primary treatment goals is to increase cognitive flexibility by, in part, decreasing EA (Hayes et al., 1999; Harris, 2009). Although the literature related to ACT and ACT processes is regularly growing, there is currently little understanding of

EA among psychotherapists. A handful of studies do, however, provide evidence that psychotherapists experience EA. One study investigated EA among addiction counselors, as measured by the Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., 2011). EA was found to account for 11% of the variance in burnout rates, independent of workplace and demographic variables (Vilardaga et al., 2011). More specifically, over and above other independent variables (e.g., workplace factors – coworker support, supervisor support, salary; demographics – age, gender, years of education), EA was a significant predictor of all three aspects of burnout: exhaustion, depersonalization, and low accomplishment (Vilardaga et al., 2011).

EA is an expectable response to anxiety and, as anxiety has been shown to precede and result from RP, it is likely that EA plays a role in whether and to what extent psychotherapists engage in RP. Although there is ample evidence that EA impacts psychotherapists in general, there currently is no research examining the relationship between EA and RP. Given the benefits of engaging in RP and the risks of avoiding RP, it is important to better articulate the impediments to RP, specifically the role of EA.

Aims and Hypotheses

RP is an important element of professional psychotherapy practice. Early theorists describe RP as the process through which professionals identify their implicit knowledge and biases and strive to assess the impact of this implicit information on their practice (Dewey, 1910; Schön, 1983). With greater clarity regarding implicit processes, professionals are better positioned to respond to potential situations in which practice may be negatively affected by those processes (Gustafsson & Fagerberg, 2004; Haarhoff et al., 2011). More recent theorists have further highlighted that RP may play a

particularly important role in bridging classroom and in vivo learning as well as research findings and clinical application (Boud & Walker, 1998). Although there is much theoretical evidence for the importance of RP, there is very little research exploring RP among psychotherapists. In addition, specific barriers to and supports of RP are unknown. EA, as a natural response to anxiety, may serve as a barrier to effective RP.

The primary aims of this project were to 1) describe the relationship between RP and EA in a sample of independent licensed psychotherapists, 2) explore among psychotherapists, the previous finding among physicians, that greater years of practice (YOP) and age predict lower levels of RP (Mamede & Schmidt, 2005), and 3) describe reported barriers to and supports of engaging in RP. Study hypotheses were that 1) higher levels of EA, as measured by greater total scores on the Multidimensional Experiential Avoidance Questionnaire (MEAQ) and MEAQ subscales, would predict lower levels of RP, as measured by the Reflective Practice Ratio (RPR), and 2) greater participant age and years of practice would correlate with lower levels of RP. The characterization of RP among psychotherapists was exploratory and we did not have any specific hypotheses. Of primary interest in this study were the factors reported by participants as either impeding or supporting engagement in RP.

Method

Participants

This study recruited licensed independent psychotherapists, and their equivalents from other countries, who engage in psychotherapy practice for at least one hour a week. Clinical psychology trainees were excluded due to the potentially confounding effects of structured RP during training. Based on licensure and degree requirements, it was

assumed that independently licensed psychotherapists are adults (i.e., over 18 years old) and competent to give informed consent and understand the survey. The basal threshold of at least one hour a week of psychotherapy practice was used to exclude prospective participants for whom psychotherapy practice is not a consistent part of their professional practice. No other exclusion criteria were used during recruitment. The participants were predominantly female (61%, *n* = 33; male 39%, *n* = 21; Table 2). Participants reported a mean age of 44.87 years (*SD* = 13.42, range = 26-63) and an average of 16.31 years of practice (*SD* = 11.13, range = 1-40). 55.6% of participants were practicing with a Master's degree, 27.8 % with a Ph.D., and 16.6% did not report their degree. Most participants practiced in the United States of America (55.6% in Massachusetts, 27.8% in another state) and 16.6% were practicing in another country. Participants reported Cognitive Theory as the most influential orientation on their practice, with Behavioral and Psychodynamic Theories as the second-most influential orientations. 77.3% of participants reported that their psychotherapy approach is mostly or primarily integrative.

Table 2

Sample Characteristics

	M	*SD*	range
Age	44.87	13.42	26 – 68
Years of Practice	16.31	11.13	1 – 40
Professional Hours	31.13	14.35	2 – 60
Clinical Hours	16.07	9.79	0 – 38
Caseload	24.78	32.37	0 – 200

Participants were recruited using several methods, including word of mouth and distribution of the link to the online survey via professional organizations. Independent licensed psychotherapists known to these researchers were provided information about

the survey and asked to participate and distribute the survey. Both international and domestic professional associations were asked to distribute the link to the online survey, including relevant American Psychological Association divisions (e.g., Division 12 – Society of Clinical Psychology, Division 17 – Society of Counseling Psychology) and the Society the Exploration of Psychotherapy Integration (an international organization). Please see the appendices for recruitment materials (Appendix A) and the survey (Appendix B). Anticipating a medium effect size for one predictor (total score on MEAQ) with one-tailed significance, power analyses with G*Power indicated a necessary sample size of 88 (Erdfelder, Faul, & Buchner, 1996).

Measures

The Multidimensional Experiential Avoidance Questionnaire (MEAQ). The MEAQ (Gamez, Chmielewski, Kotov, Ruggero, & Watson, 2011) is a 62-item self-report measure of experiential avoidance (EA). Individuals are asked to rate the extent to which they agree with each item/statement on a scale from 1 (*strongly disagree*) to 6 (*strongly agree*). Higher totals represent higher levels of experiential avoidance. Sample items include "I'd do anything to feel less stressed," "It takes me awhile to realize when I'm feeling bad," and "Fear or anxiety won't stop me from doing something important" (reverse-scored). The MEAQ was developed to address some of the perceived limitations of the Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004), including the need to increase internal consistency and broaden the assessment of different elements of EA.

The items load onto six subscales: behavioral avoidance, procrastination, distraction/suppression, repression/denial, distress aversion, and distress endurance

(Gamez et al., 2011). The subscales were validated with five different samples, including two clinical samples, two student (undergraduate) samples, and one community sample. The behavioral avoidance subscale consists of eleven items that are associated with overt avoidance of physical distress (average Cronbach's α = .87; current study Cronbach's α = .88). The procrastination subscale consists of seven items that assess participants' attempt to delay distress (average Cronbach's α = .82; current study Cronbach's α = .86). The distraction/suppression subscale consists of seven items assessing participants' attempts to suppress or ignore distress (average Cronbach's α = .84; current study Cronbach's α = .88). The repression/denial scale consists of thirteen items asking participants to rate the extent to which they attempt to dissociate from distressing feelings (i.e., lack of awareness of distress; average Cronbach's α = .85; current study Cronbach's α = .77). The distress aversion scale consists of thirteen items that assess the extent to which participants hold a negative attitude toward distress (i.e., non-acceptance of distress; average Cronbach's α = .86; current study Cronbach's α = .83). The distress endurance subscale consists of eleven items that assess participants' reported willingness to accept distress and act effectively (average Cronbach's α = .81; current study Cronbach's α = .87; Gamez et al., 2011). The total MEAQ score had a Cronbach's α = .93 across the five samples, in the current study Cronbach's α = .87. The measure developers also provided convergent and discriminant data using multiple measures of avoidance, negative affect, and personality factors. They were careful to note that, due to the wider range of behavior assessed in the MEAQ, the moderate correlation between the MEAQ and the AAQ-II was expected and the correlations between the subscales and individual measures is a more accurate assessment of convergence (Gamez et al., 2011).

Reflective Practice Ratio. There are also a few measures designed to assess RP ability and/or individuals' ability to engage in aspects of RP (e.g., case conceptualization, critical incident review); however, these measures are meant to assess individuals' ability to engage in RP, rather than characterize, naturalistically, RP. To measure RP and characterize RP among independent licensed psychotherapists, a set of self-report questions was developed to directly address the research questions (see Appendix B). Participants' engagement in RP was measured using a Reflective Practice Ratio (RPR). The RPR is the ratio of hours spent engaged in psychotherapy practice to hours spent engaged in RP. The number of hours a participant spends engaged in RP is most meaningful when considered in the context of the total number of hours spent in psychotherapy practice. For example, both participant A and B may report three hours of RP a week, but participant A engages in ten hours of psychotherapy practice a week and participant B engages in twenty hours of psychotherapy practice a week – participant A clearly devotes a larger proportion of time to RP than participant B. Using the RPR ensured that the *degree* to which RP is incorporated into professional activities is emphasized, rather than simply a quantity without context.

Brief questions about RP. A series of questions were designed to broadly evaluate the participant's beliefs about the relative importance of the RP. Participants were asked to rate the degree to which they agreed with six statements using a five-point likert scale (0 = completely disagree to 4 = completely agree). Two statements were worded in the opposite direction (questions 2 and 5). Example statements are "Psychotherapists should be required to engage in RP" and "Many things a psychotherapist needs to take care of are more important than RP." Statements varied in

how strongly they presented RP as an essential and one of the most important tasks in professional psychology. In addition, two statements were included that did not ask participants to evaluate the relative importance of RP compared to other professional tasks (e.g., RP is a valuable component of psychotherapy practice). Participants were also asked to report, in a free answer format, factors that impede or support their engagement in RP.

Procedure

The survey was available as an online survey. Data was collected from June 2015 to December 2016. In recruitment material, participants were given a brief description of the study and procedures for accessing and submitting the survey (see Appendix A). The online survey was administered via the online service that was approved by Suffolk University, Qualtrics. Of note, Qualtrics did not collect information on the number of times the survey was opened and potential participants who elected not to participate. The first page of the survey consisted of a brief description of the study and the informed consent (see Appendix B). Participants were offered the opportunity to win one of three $100 gift cards to Amazon.com, free access to a 1.5 CE credit course from tzkseminars.com, or the option to refuse compensation for their participation. Although protected health information and identifying information (e.g., name, address) was not collected for the purposes of consent or data analysis, participants who opted to be entered in the raffle or to receive the free CE course were asked to provide an email address for distribution of the chosen compensation. For participants who received the free CE course, email addresses were erased after distribution of instructions for accessing the CE course. For participants who chose to be entered in the raffle, email

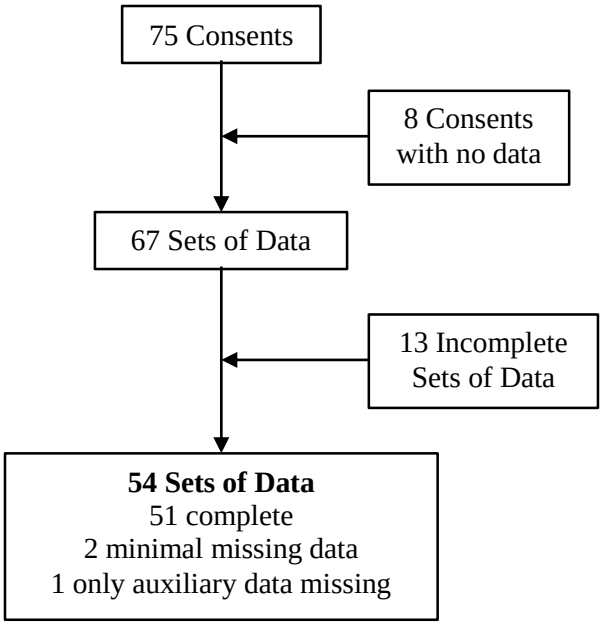
addresses were kept until the drawing. Raffle winners were contacted and informed that in order to receive the gift card, their first and last name would need to be retained, per university policy. They were given the option to consent to this retention of personal information and receive the gift card, receive the free CE course, or elect not to receive any compensation. If a raffle winner elected not to receive the gift card, another winner was drawn and the process was repeated. Once all giftcards were distributed, all remaining email addresses were deleted.

Results

Figure 1 documents participant flow. Of the 75 participants who consented to participate, 54 participants' data sets were sufficiently completed to be used in analyses. 51 participants completed all items for the study. Two participants had one to three missing responses on the MEAQ. Group means for the particular missing questions were used as replacement values to complete these participants' data sets.

Figure 1

Data Inclusion Flowchart

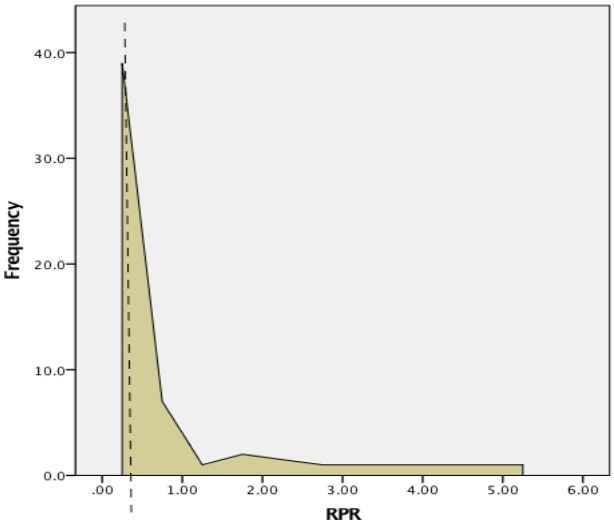


All responses for time-based variables were standardized (i.e., converted to minutes). Variables contributing to the primary variables of interest were calculated (see Appendix C: Codebook). Subscale scores were calculated for the Multidimensional Experiential Avoidance Questionnaire (MEAQ). Several steps were necessary to calculate the Reflective Practice Ratio (RPR). First, percentage of RP time focused on what the therapist brings (*personalactual*; e.g., 50%) and percentage of RP time focused on therapist's reactions (*reactactual*) were converted to decimal numbers (respectively, *personalper* and *reactper*; e.g., .50). These two new variables were then summed to create *introper*, the percentage of RP time focused introspectively. Then the amount of time spent engaged in introspective RP, in minutes, was calculated. Finally, this was divided by the reported total clinical time, also in minutes, to yield RPR.

All variables were examined for normality and violations of assumptions for t-tests. Due to non-normality, RPR was treated as a nominal variable, and the sample was divided into two groups based on a median cut (RPR = 0.33; Figure 2).

Figure 2

Distribution of RPR with Median Cut



This resulted in a "low" RP group (RPR < 0.33) of 26 participants and a "high" RP group (RPR ≥ 0.33) of 28 participants; these group sizes were sufficiently large to allow for statistical analysis of group differences. The low RP group was 46% female (*n* = 12) and 54% male (*n* = 14) and the high RP group was 75% female (*n* = 21) and 25% male (*n* = 7). The low and high RP groups were comparable in terms of age, years of practice, professional hours and clinical hours. Table 3 presents some demographics and descriptive data for RPR for the whole sample in comparison with the low RP and high RP groups. IBM SPSS 24 was used for all data analyses.

Table 3

Sample Characteristics by Group

	Whole Sample (*n* = 54)		Low RP (*n* = 26)		High RP (*n* = 28)	
	M (*SD*)	Range	*M* (*SD*)	Range	*M* (*SD*)	Range
Age	44.87 (13.42)	26–68	45.27 (15.73)	26–68	44.50 (11.15)	29–65
Years of Practice	16.31 (11.13)	1–40	15.73 (12.64)	1–40	16.86 (9.73)	3–40
Professional Hours	31.13 (14.35)	2–60	30.12 (15.22)	5–60	32.07 (13.70)	2–54
Clinical Hours	16.07 (9.79)	0–38	13.04 (8.58)	0–34	18.89 (10.15)	4–38
Caseload	24.78 (32.37)	0–200	16.04 (16.67)	0–75	32.89 (40.32)	3–200
RPR	0.69 (1.11)	0–5.33	0.13 (0.09)	0–0.31	1.2 (1.36)	0.33–5.33

Hypothesis 1: Higher levels of EA will predict lower levels of RP.

Independent samples t-tests were conducted to compare the MEAQ total and subscale scores for the low RP group and the high RP group (Table 4). Significant

differences in scores for the low RP group (*M* = 145.42, *SD* = 32.28) and the high RP group (*M* = 133.39, *SD* = 26.2), *t* (52) = 1.51, *p* = .137, were not found but the intergroup differences were in the hypothesized direction. The effect size of the difference in the means (mean difference = 12.03, 95% *CI*: -3.97 to 28.03) was small to moderate (Cohen's *d* = 0.41).

Table 4

MEAQ Total and Subscales t-tests Comparing Low and High RP Groups

	Low RP group *M* (*SD*)	High RP group *M* (*SD*)	*t*	df	*p*	Mean Diff.	95% CI	Cohen's *d*
BA	25.42 (8.43)	23.79 (7.17)	0.77	52	.445	1.64	[-2.63, 5.90]	0.21
DA	29.38 (8.96)	26.54 (7.14)	1.30	52	.200	2.85	[-1.56, 7.26]	0.35
Pro	20.54 (7.07)	20.68 (6.24)	-0.08	52	.939	-0.14	[-3.78, 3.50]	-0.02
DS	18.69 (6.89)	16.21 (4.68)	1.56	52	.126	2.47	[-0.72, 5.67]	0.42
RD	27.08 (7.53)	22.61 (5.77)	2.46*	52	.017*	4.47	[-0.82, 8.12]	0.67
DE	52.69 (8.80)	53.43 (6.75)	-0.35	52	.730	-0.74	[-5, 3.52]	-0.09
T	145.42 (32.28)	133.39 (26.20)	1.51	52	.137	12.03	[-3.97, 28.03]	0.41

Note. CI = confidence interval; BA = behavioral avoidance; DA = distress aversion; Pro = procrastination; DS = distraction and suppression; RD = repression and denial; DE = distress endurance; T = total; * $p<.05$

The MEAQ Repression and Denial (MEAQRD) subscale mean score was significantly higher in the low RP group (*M* = 27.08, *SD* = 7.53) than the high RP group (*M* = 22.61, *SD* = 5.77), *t* (52) = 2.46, *p* = .02. The effect size of the magnitude of difference in the means (mean difference = 4.47, 95% *CI*: 0.82 to 8.12) was moderate (Cohen's *d* = 0.67). There were no statistically significant differences in mean scores for any other subscale; however, the magnitudes of difference in the means were moderate for the Distress Aversion subscale (mean difference = 2.85, 95% *CI*: -1.56 to 7.26, Cohen's *d* = 0.35) and

the Distraction and Suppression subscale (mean difference = 2.47, 95% *CI*: -0.78 to 5.73, Cohen's $d = 0.42$).

Comparison of EA in high and low RP groups by clinical setting.

As institutional factors are posited to impact RP, the sample was divided into two groups to further explore RP. Institutions require their psychotherapists to engage in certain activities, such as meetings and documentation that are not generally required of private practitioners, which places a higher demand on the time of those practicing in institutions. The sample was divided into psychotherapists whose primary clinical setting is private practice and those whose primary setting is within a larger institution (Table 5). The institution-based sample includes participants whose primary clinical setting is a group practice, inpatient hospital, outpatient hospital, partial hospital, residential program, community mental health clinic, or research clinic. Independent samples t-tests were conducted to compare mean scores on the MEAQ and its subscales in the high RP and low RP groups for all institution-based participants ($n = 35$) and all private practice participants ($n = 17$).

Table 5

Primary Clinical Settings

	N	%
Private practice	17	31.5
Group practice	5	9.3
Inpatient	1	1.9
Outpatient	8	14.8
Partial hospital	2	3.7
Residential	1	1.9
Community MH	15	27.8
Research	3	5.6
Missing	1	1.9

Comparisons of mean scores between high and low RP groups on MEAQ total and subscale scores for institution-based participants are summarized in Table 6. The difference in MEAQ total scores for the low RP group (M = 149.11, SD = 35.78) and the high RP group (M = 130.78, SD = 29.18), t (34) = 1.69, p = .101, was not statistically significant but was in the hypothesized direction. The effect size of the difference in the means (mean difference = 18.33, 95% *CI*: -3.78 to 40.45) was moderate (Cohen's d = 0.56) and larger than that found in the analysis using the full sample.

Table 6

MEAQ Total and Subscales t-tests Comparing Low and High RP Groups, Institution Based Participants

	Low RP group *M* (*SD*)	High RP group *M* (*SD*)	*t*	df	*p*	Mean Diff.	95% CI	Cohen's *d*
BA	26.89 (9.06)	23.94 (7.92)	1.04	34	.306	2.94	[-2.82, 8.71]	0.35
DA	31.33 (8.94)	25.50 (7.40)	2.13	34	.04*	5.83	[0.27, 11.39]	0.71
Pro	20.78 (8.16)	20.28 (6.36)	0.21	34	.839	0.50	[-4.46, 5.46]	0.07
DS	19.94 (7.28)	16.22 (4.80)	1.81	34	.079	3.72	[-0.45, 7.90]	0.60
RD	27 (8.18)	21.83 (5.44)	2.23	34	.032*	5.17	[0.46, 9.87]	0.74
DE	53.83 (9.39)	54 (6.83)	-0.06	34	.952	-0.17	[-5.73, 5.39]	-0.02
T	149.11 (35.77)	130.78 (29.18)	1.69	34	.101	18.33	[-3.78, 40.56]	0.56

Note. CI = confidence interval; BA = behavioral avoidance; DA = distress aversion; Pro = procrastination; DS = distraction and suppression; RD = repression and denial; DE = distress endurance; T = total; * p<0.05

Similar to findings for the full sample, MEAQRD subscale mean scores were significantly different between the low (M = 27, SD = 8.18) and high RP groups (M = 21.83, SD = 5.44), t (34) = 2.23, p = .032, such that the high RP group had lower mean Repression and Denial scores. The effect size of the difference in the means (mean difference = 5.17, 95% *CI*: 0.46 to 9.87) was moderate to large (Cohen's d = 0.74). The

MEAQ Distress Aversion (MEAQDA) subscale mean scores was also significantly different between the low (M = 31.33, SD = 8.94) and high RP groups (M = 25.50, SD = 7.40), t (34) = 2.13, p = .04, such that the high RP group had lower mean MEAQDA scores. The magnitude of difference in the means (mean difference = 5.83, 95% *CI*: 0.27 to 11.39) was also moderate to large (Cohen's d = 0.71).

Among the private practice-based participants, there were no significant differences in mean scores between the high and low RP groups on any of the subscales or the total score (Table 7).

Table 7

MEAQ Total and Subscales t-tests Comparing Low and High RP Groups, Private Practice Participants

	Low RP group *M* (*SD*)	High RP group *M* (*SD*)	*t*	df	*p*	Mean Diff.	95% CI	Cohen's *d*
BA	22.43 (6.48)	23.50 (5.99)	-0.35	15	.73	-1.07	[-7.57, 5.43]	-0.17
DA	25.57 (8.26)	28.40 (6.59)	-0.79	15	.444	-2.83	[-10.50, 4.84]	-0.38
Pro	20.57 (3.99)	21.40 (6.29)	-0.31	15	.764	-0.83	[-6.60, 4.54]	-0.16
DS	16 (5.66)	16.20 (4.71)	-0.08	15	.938	-0.20	[-5.57, 5.17]	-0.04
RD	27.29 (6.82)	24 (6.38)	1.02	15	.326	3.29	[-3.82, 10.40]	0.50
DE	50.29 (7.74)	52.40 (6.85)	-0.60	15	.561	-2.11	[-9.70, 5.47]	-0.29
T	138.57 (23.76)	138.10 (20.28)	0.04	15	.965	0.47	[-22.37, 23.31]	0.02

Note. CI = confidence interval; BA = behavioral avoidance; DA = distress aversion; Pro = procrastination; DS = distraction and suppression; RD = repression and denial; DE = distress endurance; T = total; * p<.05

In contrast to the findings for the institution-based participants, the difference in MEAQ total scores for the low RP group (M = 138.57, SD = 23.78) and the high RP group (M = 138.10, SD = 20.28), t (15) = 0.04, p = .47, was not statistically significant and the effect size of the difference in the means (mean difference = 0.47, 95% *CI*: -22.37 to 23.31) was

small (Cohen's d = 0.02). MEAQRD subscale mean scores were also not significantly different between the low (M = 27.29, SD = 6.82) and high RP groups (M = 24, SD = 6.38), t (15) = 1.02, p = .326, and the effect size of the difference in the means (mean difference = 3.29, 95% *CI*: -3.82 to 10.40) was moderate (Cohen's d = 0.50). The MEAQDA subscale mean scores were not significantly different between the low (M = 25.57, SD = 8.26) and high RP groups (M = 28.40, SD = 6.59), t (15) = -0.79, p = .444, and the magnitude of difference in the means (mean difference = -2.83, 95% *CI*: -10.5 to 4.84) was also small (Cohen's d = -0.38).

Hypothesis 2: Age and years of practice will be negatively correlated with RP.

The relationships between age, years of practice (YOP), and RP were investigated. Independent samples t tests were performed and no significant group differences were observed between the low and high RPR groups for either age (t (52) = 0.21, p = .835) or YOP (t (52) = 0.37, p = .713). Therefore, correlations were performed to further examine relationships between the variables. Due to RPR's non-normality, these relationships were examined using a nonparametric test, Spearman Rank Order Correlation (Table 8). As would be expected, age and years of practice were significantly positively correlated at $r_s(54) = .88$, $p < .001$. When the sample was examined as a whole, there was a significant positive correlation between YOP and RPR $r_s(54) = .302$, p = .013, explaining 9% of the variance ($r_s^2 = .091$). For further exploration, additional correlations were examined within the high and low RP groups separately. In the low RP group, neither relationship was significant. In the high RP group, both age and YOP were significantly positively correlated with RPR, respectively, $r_s(28) = .484$, $p = .005$, $r_s^2 = .234$ and $r_s(28) = .498$, $p = .003$, $r_s^2 = .248$, accounting for approximately 25% variance

in both relationships.

As in Hypothesis One analyses, the sample was divided by primary clinical setting into primarily private practice-based participants and primarily institution-based participants (e.g., hospital, research clinic).

Table 8

Correlations Between Age and Years of Practice and Reflective Practice by Group

Group		Age and RPR	YOP and RPR
All Cases n = 54	r_s p r_s^2	.175 .103 .03	.302* .013 .091
Low RPR n = 26	r_s p r_s^2	.156 .223 .024	.302 .067 .091
High RPR n = 28	r_s p r_s^2	.484** .005 .234	.498** .003 .248
Private practice primary setting n = 17	r_s p r_s^2	.087 .37 .007	.217 .202 .047
Institution-based primary settings n = 36	r_s p r_s^2	.357* .016 .127	.475** .002 .225

Note. RPR = reflective practice ratio; YOP = years of practice; * p<.05 (one-tailed); ** p<.01 (one-tailed)

Neither relationship was significant in the private practice group (age and RPR: $r_s(17) = .087$, $p = .37$, $r_s^2 = .007$; YOP and RPR: $r_s(17) = .217$, $p = .202$, $r_s^2 = .047$), explaining approximately 1% and 5% of the variance, respectively. In the institution-based group, the correlation between age and RPR, $r_s(36) = .357$, $p = .016$, was significant, explaining 13% of the variance ($r_s^2 = .127$). The correlation between YOP and RPR, $r_s(36) = .475$, p

= .002, was also significant and explained 23% of the variance (r_s^2 = .225).

Qualitative analysis of supports of and barriers to reflective practice.

Participants indicated that they value RP. Their responses to the six statements assessing beliefs about the importance of RP indicated general agreement with statements supporting RP as a priority and disagreed with statements that placed RP lower in priority than other clinical/professional duties (Table 9). Of the 75 participants who consented to the study, 57 reported, via open-ended survey questions, factors that support or impede their engagement in RP. Participant responses are summarized in Table 10.

Table 9

Responses to Statements About Importance of Reflective Practice

	completely disagree *n* (%)	somewhat disagree *n* (%)	neither agree nor disagree *n* (%)	somewhat agree *n* (%)	completely agree *n* (%)
1. RP is a valuable component of psychotherapy practice.	0 (0)	0 (0)	21 (36)	38 (64)	0 (0)
2. RP takes time away from other work I need to get done.*	20 (34)	15 (25)	13 (22)	10 (17)	1 (2)
3. Psychotherapists should be required to engage in RP.	0 (0)	4 (6)	11 (19)	21 (36)	23 (39)
4. RP is an essential element of my psychotherapy practice.	0 (0)	1 (2)	6 (10)	22 (37)	30 (51)
5. Many things a psychotherapist needs to take care of are more important than RP.*	16 (27)	18 (30)	14 (24)	8 (14)	3 (5)
6. I make RP a priority.	0 (0)	3 (5)	11 (19)	32 (54)	13 (22)

Note. *statement is reverse scored

The reported factors were divided into two main categories based on how processes tend

to be divided in common definitions of RP: 1) institutional and contextual factors and 2) factors related to the client and therapy. In the institutional and contextual factors category, participant responses were further divided into factors related to colleagues (e.g., supervisors who support or fail to prioritize RP) and factors that impact how time is used (e.g., time built in for RP or too great a clinical load). Factors in the client and therapy category were examined through the lens of areas of RP presented in the survey: 1) what the client brings in (e.g., difficult clinical presentations), 2) what happens in therapy (e.g., therapy that is stuck or going too well), 3) what the therapist brings in (e.g., feeling overwhelmed in other aspects of practice or personal drive to practice effectively), and 4) therapist reactions to session (e.g., noticing strong emotions or being uncomfortable with session progress).

Table 10

Supports of and Barriers to Reflective Practice

Institutional Factors	Supports	Barriers
Colleagues	- Supportive colleagues who are interested in RP - frequent contact with - feedback from - conflict with	- colleagues that see RP as a waste of time - critical supervisor -isolated work space/low interaction
Time	- lighter clinical load - time between sessions - control over schedule - greater reimbursement rate (lighter clinical load) - able to bill for consultation - reliable clients (less intakes and paperwork) - trainings and meetings	- too little time - other priorities/commitments - lack of flexibility in schedule - too many no-shows - too great of a clinical load - insurance paperwork - no institutional priority - trainings and meetings
Client/Therapist Factors		
What clients bring in (e.g., case conceptualization)	- difficult topics (e.g., sexuality) - assessment (concerning presentation) - transference (e.g., clients' observations of therapist) - significant emotional dysregulation	- reluctant to change - certain clinical presentations (e.g., unbridled mania, active problematic substance abuse, and borderline features) - difficult to figure out clinical presentations
What to do in session (e.g., treatment planning)	- termination - treatment failure/negative outcomes - challenging dyadic interactions - clinical ruptures/critical incidents - stuck/stalled therapy - treatment going too well - client feedback - not knowing how to address a particular clinical presentation	- treatment going well/too easy - uneventful sessions - client appears satisfied
What the therapists bring in (e.g., personal history and worldview)	- orientation - desire/value to do a good job - training/habits - feeling stretched clinically - high stress and burnout - vicarious trauma - cultural factors	- feeling overwhelmed/divided attention - competing demands (e.g., family) - mood - busy day
Therapist reactions to session (e.g., counter-transference)	- counter-transference - notice responses are different than expected - notice strong emotional reaction - personal history triggered - give example that is too personal - feeling curious - recognizing a potential mistake	- counter-transference - discomfort with case progress - evocation of powerful emotion

Discussion

Study Rationale and Aims

As articulated by Donald Schön in 1983, there is one core difference between a technician and a professional, which is reflective practice (RP). This distinction is more important than ever as the demand for transparency of process grows in fields in which professional competencies are being more clearly articulated and more frequently assessed, like psychotherapy practice. As Schön wrote, professionals go beyond a formulaic application of knowledge to a continuous consideration of what they do, why they do it, how they can do it better, and what is getting in the way. The importance of RP in psychotherapy practice is affirmed in both theory and practice guidelines; however, research is lagging in terms of understanding how RP is integrated into daily practice for post-training psychotherapists. Moreover, there is no current research addressing the factors that support or impede psychotherapists' engagement in RP.

This study had three aims to help better understand the role of RP in the professional practice of psychotherapists. Aim One explored how experiential avoidance (EA) was related to RP. Aim Two examined the impact of age and years of practice (YOP) on RP. Finally, Aim Three, using qualitative data, described some aspects of participants' practice and how it might relate to their use of RP. In particular, Aim Three strove to broadly articulate factors that impact the likelihood that a psychotherapist will engage in RP.

Differences in EA between the low and high RP groups.

The results of this study demonstrated that in this sample, differences in EA exist between psychotherapists that report a higher ratio of clinical time engaged in RP (high

RPR) and those that report a lower ratio (low RPR). Some of these differences were statistically significant. The main hypothesis, that the high RP group would have significantly lower overall EA than the low RP group, did not demonstrate differences at a statistically significant level. However, the difference between groups was in the hypothesized direction with a moderate effect size, indicating conditional support for the hypothesis.

An analysis of the facets of EA was undertaken to further examine the relationship. This analysis found a statistically significant difference between the high RP group and low RP group on the repression and denial of distress subscale of the MEAQ (MEAQRD). MEAQRD assesses respondents' tendency to dissociate or distance themselves from distress (Gamez et al., 2011). The finding here can be framed in terms of participants' responses to distress (i.e., emotion regulation strategies). More specifically, when someone experiences distress, there are two main ways that they can approach managing the emotion: actively processing the experience, RP, and creating distance from the emotion. Creating distance from the emotion is a form of dissociation.

It is possible to understand EA in the context of dissociation. Dissociation represents the individual's effort to completely disconnect from experience in order to avoid distress, and EA is the drive to get rid of unwanted internal experiences with the end goal being to experience as little distress as possible. Never consciously experiencing distress is as close to a complete lack of distress that someone could achieve. Given the relatively elevated level of dissociation in the low RP group, psychotherapists in the low RP group are more likely to elect an EA-based strategy than engaging in RP to cope with unwanted or unaccepted internal experiences. In fact, these psychotherapists may only be

vaguely aware of times that engaging in RP could be helpful. Thus, engaging in RP would be doubly difficult as these psychotherapists would have to first learn to recognize their distress and then choose to engage in RP, requiring two choices to not engage in dissociation.

It is possible that the severity of distress plays a role here. For psychotherapists who are naturally inclined away from EA (i.e., toward RP), higher levels of distress may actually make them more likely to engage in RP. These psychotherapists prioritize RP to process the emotions and distress because they have found it to be an effective method of managing their emotions and allowing them to remain effective. Such processing could take on a variety of forms. Some methods are fairly structured, such as critical incident analysis and process notes. Others are less so, such as peer supervision and journaling.

Regardless of the form, the purpose of the processing, in the context of RP, is to advance practice. For example, a psychotherapist could find herself so emotionally activated in a session that she missed something important shared by the client. She could speak about it with a trusted colleague and examine what role, if any, her personal history may have played in the activation. It is likely that a greater understanding of the possible impact of her personal history would allow her to be aware of that possible activation and remain effective in session, even when activated.

For psychotherapists who tend towards EA, higher levels of distress may only reinforce their drive to avoid and, therefore, increase the drive toward EA. In addition to natural inclinations towards one or the other response, there may be additional contextual factors that impact psychotherapists' response to distress. For example, if psychotherapists have very little time before their next client or meeting, they do not have

time to engage in RP and may need to utilize some form of EA, such as distancing themselves from their experience of distress, in order to be effective in their next session or meeting.

Among psychotherapists who work primarily in private practice, there were no significant differences between high and low RP groups on any of the MEAQ subscales or the total score. Among the institution-based participants, the MEAQRD and MEAQDA subscale scores were significantly different between the low and high RP groups. These results indicate that factors related to the clinical setting impact the relationship between EA and RP. It is likely that the pressure of institutional demands on time add to the natural inclination to avoid optional tasks that require additional time and effort. Psychotherapists may find it difficult to shoulder the discomfort of adding activities to an already strained schedule, especially if those activities could potentially lead to further distress (e.g., RP). However, there is a subset of psychotherapists who are more willing to expend the effort to engage in a potentially distressing activity (e.g. RP) and make room for such activity in a busy schedule.

Future investigations could focus on institution-based psychotherapists, comparing the ways in which institutions vary and explore the impact those variations have on EA, RP, and the relationship between the two. There should also be efforts to understand how psychotherapists that chose to engage in RP differ from those who do not. As adding time to engage in RP to an already busy schedule is a deliberate choice, it is likely that they have beliefs and/or experiences that value RP as an important element of their practice. Such beliefs could include that RP is important for processing their own

reactions to their work, deepening their conceptualization of clients, or as part of the regular evaluation of treatment efficacy.

Psychotherapists engage in more RP over time.

For the second aim, it was hypothesized that age and YOP would be negatively correlated with RP. The results revealed that participants' engagement in RP was significantly positively correlated with greater age and experience, particularly among participants who reported higher levels of RP. In addition, when considered by setting, in participants who were institution-based, RP increased significantly over time (i.e., as age and YOP increased). There are several possible explanations for this result, which was not as predicted. This hypothesis was based on prior research with a group of Brazilian physicians that found negative correlations between RP and both age and YOP (Mamede & Schmidt, 2005). In explaining the results of their study, Mamede and Schmidt (2005) suggested that general complacency, as well as systemic and institutional demands (e.g., reimbursement rule, institutional priorities), contribute to the decrease in RP over time. Many psychotherapists are subject to similar systemic and institutional demands as their sample, and, yet, engagement in RP tended to increase as participants' experience (i.e., age and YOP) increased. In fact, when private practice-based participants (i.e., low or no institutional demands) were removed from the sample, the positive correlations between age and RP and YOP and RPR became stronger, providing further evidence that there is an essential difference between the two samples of physicians and psychotherapists.

In addition to the differences in practice between Brazil and the United States and the difference in methodology for measuring RP, differences in training guidelines may play a role. While the Association of American Medical Colleges' (AAMC, 1998) report

on education guidelines notes several core expectations of physicians (altruism, knowledge, skill, and dutifulness) imply the value of RP, it does not explicitly state RP (or any variation of the term) as a specific expectation for professional practice. For example, under the altruism guideline, it states that students must demonstrate "the capacity to recognize and accept limitations in one's knowledge and clinical skills" (AAMC, 1998, p. 5). Similarly, in their program requirements for accreditation, the Accreditation Council for Graduate Medical Education (ACGME) notes several skills that are typically associated with RP (e.g., "Practice-based learning and improvement…identify strengths, deficiencies, and limits in one's knowledge and experience;" p. 10) but does not specifically use the term RP or its variations (ACGME, 2017).

In contrast, as noted previously, the APA specifically recognizes RP as a core competency for professional practice and explicitly articulates it as a training goal (APA, 2006). Thus, the explicit focus on RP in psychotherapy-based professions almost certainly accounts for some of the differential findings in physicians and psychotherapists. As an explicit training focus, psychotherapists are introduced to RP as an essential element of practice early on and learn how to integrate it into daily practice. This is meant to support RP as an automatic behavior. On the other hand, physicians must first notice the need for and importance of RP in practice and then find the appropriate supervision and training to integrate RP into their daily practice. In this way, psychotherapists are more likely to effectively integrate RP into their practice earlier in their careers than physicians. Perhaps, for physicians, RP is not sufficiently integrated

into regular practice to survive the demands of increasing responsibility over their careers, thus leading to a decrease in RP.

That being said, there is a strong and growing movement to increase the explicit integration of RP into medical education. In fact, medical educators at various institutes and in certain countries have already implemented change and are actively incorporating and highlighting reflection as an essential element of case conceptualization and professional practice. In 2016, Butani, Bannister, Rubin, and Forbes surveyed medical educators in pediatrics concerning their perceptions of the value of RP (its importance as a skill, to be modelled for students, and as an element of feedback), understanding of the integration of RP in curricula, and the extent to which they perceive themselves as understanding the concept and able to train students in RP. Participants reported broad agreement that RP is important and valuable. They also demonstrated a solid understanding of RP as important for analyzing events and promoting change but a more limited understanding of the kinds of events that could or should trigger RP (Butani et al., 2016). Lachman and Pawlina (2006) presented a strong argument for increased RP integration ins traditionally "pure content" courses, such as gross anatomy, and provided examples of how such incorporation was already underway at several institutes. Further, the Canadian Medical Education Directives for Specialists, directives governing accreditation of residency and fellowship programs in Canada, specifically requires that physicians evidence commitment to ongoing reflective learning (Royal College of Physicians and Surgeons of Canada, 2017).

There are several additional factors that may contribute to this unexpected finding, that in this sample RP *increased* over time (i.e., greater age and YOP). Although the

health and well-being of patients is a common goal of all health professions, medicine and psychotherapy measure change differently and have distinct methods for facilitating change. In medicine, the core task is to identify illness and apply an appropriate and effective cure. While not necessarily simple, the process of identifying symptoms and an appropriate solution is, essentially, formulaic.

There is a similar process by which problematic or undesirable behaviors are identified and then addressed in psychotherapy. However, in psychotherapy, the psychotherapists are the primary tool of intervention. The manner in which psychotherapists engage with the client, the language that is used, and the selection of what information would be most useful at the moment, are just a few of the factors that impact the efficacy of psychotherapy. All of these processes require a personal and emotional investment from psychotherapists that can be impacted by their emotional state. In this way, the very practice of psychotherapy requires some minimum level of RP to competently navigate the complexity of psychotherapists' personal presence being an active ingredient in treatment. In-the-moment RP supports psychotherapists' ability to consider their own emotional state and reactions, the impact of that state on the psychotherapy work, and to adjust as needed. In the absence of such a process, psychotherapists may risk decreased efficacy due to their own emotional state, personal history, and personal biases playing an inappropriately large role in selecting the content and tone of sessions.

There may be additional processes by which psychotherapists' engagement in RP impact outcomes. Psychotherapeutic techniques generally endeavor to teach the clients how to observe themselves and respond differently (presumably more effectively). By its

very nature, the observation of ourselves is a form of RP. For example, when clients complete a record of their thoughts and how each of those thoughts makes them feel, they are being taught to observe their own thoughts and consider the impact those thoughts have on their emotions and behavior. It is possible that psychotherapists' ability to articulate and teach such skills is impacted by their own ability to engage in RP and being able to draw on personal experience. Thus, psychotherapists' own RP may support their ability to teach clients RP-based skills. Future research should address this question.

Separate from the essential differences between psychotherapists and physicians, there are additional mechanisms that could contribute to this differential finding. It is possible that over time (i.e., as age and YOP increase), some of the institutional factors that impede RP become less restrictive. Perhaps, as experience increases, psychotherapists benefit from increased efficiency with their time and, therefore, have more time to engage in RP. Psychotherapists with greater seniority may also have more freedom to determine their own schedule (i.e., increased in flexibility) or enter partial retirement (i.e., working part-time), which would also increase the time they have to engage in RP. It is possible that the ways in which physicians' experiences differ from those of psychotherapists (e.g., different clinical emphasis) leads them to engage in RP less over time. Perhaps for physicians, the increased flexibility in time is not comparable due to systemic differences in practice or they may not take advantage of such freedoms.

In addition to considering why RP increases over time for psychotherapists, it is worth considering the possible role of decreases in EA that lead to increases in RP. It is well known that repeated exposure to a feared or avoided stimuli leads to habituation, a decrease in distress or fear, and a decrease in avoidance (Barlow, 2004). Applying this

principle, psychotherapists' exposure to RP and the attendant distress naturally leads to a decrease in distress through habituation. As distress decreases, so too does the urge to avoid RP, thereby leading to an increase in engagement in RP. In contrast, as RP is not emphasized as an essential part of practice, physicians may not be regularly exposed to RP and, thus, do not habituate to associated distress.

It is also possible that as psychotherapists gain experience, they come to appreciate more fully the value of RP. This could lead to psychotherapists prioritizing engagement in RP when making choices about how to use their time. More experienced psychotherapists may have more clearly articulated their values and, in the increasing recognition that RP is an essential element of professional practice, have a stronger commitment to using non-session time to engage in RP. These possibilities highlight the importance of exposing psychotherapists to the possible distress associated with RP early in their careers. Supervisors could also discuss the importance of RP and explicitly address the benefits of prioritizing RP in busy schedules.

Discussion of Qualitative Findings

As noted previously, although the importance of RP in psychotherapy does not yet have substantial empirical support, there is substantial theoretical support and a wide-spread assumption of the utility of RP, as evidenced by its inclusion as a core competency in professional psychology (APA, 2006). Consistent with this assumption, participants in the current study indicated agreement with the belief that RP is a valuable activity and that it should be a regular element of psychotherapy practice. The current study also sought to articulate factors that facilitate or impede RP (see Table 10 for summary) as a regular element of psychotherapy practice. The factors that participants reported fell into

two broad categories, institutional factors and client-therapist factors. The first category encompasses factors that are inherent to being subject to billing and institutional requirements and related either to participants' colleagues (Colleagues category) or factors that impacted how their time is used (Time category).

Institutional Factors

The factors in the Colleagues category highlight that a work environment can impact engagement in RP by creating a milieu that is RP friendly (or not). Just as participants in Wong-Wylie's (2004) study reported, the work milieu was an important factor in the degree to which they engaged in RP. Participant responses in this study indicated that the frequency of contact with colleagues is important, such that increased frequency of contact makes engaging in RP more likely. It was also noted that the quality of interaction, for example, how open colleagues are to RP, impacted the likelihood that participants would engage in RP. An important future avenue of research is to further examine what constitutes an RP-friendly or -unfriendly environment. Such information may reveal strategies that would allow institutions to support RP at the institutional level. For example, one respondent noted that being physically isolated from colleagues decreases the likelihood that he or she will engage in RP. If further research identifies the layout of a workspace to be a significant factor for increasing interaction between colleagues and thereby increasing engagement in RP, then institutions could intentionally make decisions about office space and common space (e.g., staff lounge) to maximize such interactions.

In the Time category, how much time participants were required to engage in face-to-face sessions and their unbillable requirements (e.g., team meetings, trainings),

constituted the bulk of institutional factors that impact RP. This is consistent with the findings from Dornan et al. (2002) that time, or lack thereof, was a significant barrier to using an online diary. The implication is that, as the time spent in required activity increases, there is a decrease in flexibility in schedule, energy, and time available for engaging in RP. It is likely that institutions do not have much flexibility in terms of the number of hours that need to be billed to remain solvent.

Using this qualitative data as a starting point, future research could further explore the relationship between the time spent in required activity and time spent in RP. If, as is indicated by the current results, there is a negative correlation between the time spent in required activity and the time spent in RP, then guidelines could be provided to institutions about balancing supporting RP and required activities. Institutions and supervisors could use such guidelines to be more thoughtful about what they require of psychotherapists in terms of meetings, trainings, and administrative support in order to maximize time available for RP. Additional consideration could be given to the manner in which requirements are fulfilled and increasing the extent to which completing certain requirements, such as therapy notes, also represent instances of RP. For example, when completing the template for session notes, psychotherapists could approach the "plan" section with additional thought to the direction and intention of treatment rather than simply indicating when clients are to return for the next session.

On a personal level, psychotherapists can commit to keeping themselves as efficient as possible. As they are better able to meet institutional requirements in a timely manner, psychotherapists will have more time available for RP. In addition, these findings

indicate that psychotherapists could integrate RP into regular practice by reliably ending sessions with sufficient time to allow for some reflection before the next appointment.

Client/Therapist Factors

The second broad category included the factors related to psychotherapy. Although there was a fairly wide range of responses, two themes were highly salient - challenges to skills and therapist emotions. Challenges to skills are conceptualized as times in which skills that are an explicit and standard part of psychotherapy training are specifically challenged in some way that requires a thoughtful and deliberate response. For the most part, challenges to skills were listed as factors that support RP. The process of recognizing that one's skills are being challenged and the subsequent thought and response to the challenge is, essentially, RP. Some of the clearest examples of this are in the subcategory of "what the client brings in." Case conceptualization is a core psychotherapeutic skill and can be a very complex and challenging process. Participants noted such things as, "when something occurs that does not fit my working conceptualization" and "novelty in presenting issues" as situations that increase the likelihood that they will engage in RP. This category also included examples of when knowledge or ability to address certain topic areas is challenged, such as "sexuality as content" and addressing legal concerns.

Interestingly, several reported impediments to engaging in RP include managing potentially high levels of emotion for the psychotherapist. Participants reported many emotions that are barriers to engaging in RP: overwhelmed, stressed, tired, isolated, distracted, dislike of supervisor, and discomfort. Many of these factors were directly linked with previously discussed institutional factors related to time constraints (e.g.,

competing demands on time/attention, too much paperwork, a critical supervisor). This indicates that institutionally-based barriers actually impact RP at two levels – in the actual time available for RP and the attendant emotional cost of overwhelmed/stressed providers.

Many of these emotion-based/emotion-laden factors were reported by some participants as barriers and by others as supports. Perhaps the clearest example is that some participants reported that when they notice a strong emotional reaction, they are more likely to engage in RP while other participants reported that the evocation of powerful emotion decreased the likelihood of engaging in RP. Some participants noted that a "difficult session" (e.g., clinical rupture, emotionally dysregulated client) increases engagement in RP while others noted that it decreases engagement. As is posited in ACT, it is the evaluation of a distressing emotion as unwanted and the subsequent desire to avoid that is the precursor of EA (Hayes et al., 1999).

As indicated by the results in Aim One, the degree to which psychotherapists in this sample engage in RP was related to the degree of their tendency towards EA. A follow-up study based on these findings should investigate how quantitatively assessed differences in EA and RP are expressed qualitatively by participants. For example, participants would be asked to complete more quantitative assessments of EA and associated concepts (e.g., mindfulness and dissociative experiences). They would also be asked to provide more detailed information about their daily schedules so that the evaluation of time spent engaged in RP is determined by raters who are trained to use the same metric and have a shared understanding of the concept. For the qualitative element,

a semi-structured interview could be used to document what factors increase or decrease the likelihood of engaging RP.

For psychotherapists that tend toward engaging in RP in response to distress, supporting RP could focus on removing barriers to provide greater freedom for their existing tendency to engage in RP. For psychotherapists that tend to engage in EA in response to distress, removing barriers to RP may not be effective. Even in the absence of such barriers, these psychotherapists will likely continue to follow their existing tendency, to engage in EA in response to stress. It may be more effective to increase RP by addressing the tendency toward EA. Such methods could include training aimed at increasing recognition and tolerance of distress and be sufficiently flexible to address behavioral, emotional, and cognitive elements of EA. In addition, it would be useful to discuss as well as discussion of the benefits of engaging in RP, despite feelings of distress, and the dangers of too little RP.

Clinical Implications and Future Directions

These results directly lead to several clinical implications that could increase psychotherapist engagements in RP. On a personal level, psychotherapists can commit to finding the time and tolerating the potential distress of engaging RP. They can also deliberately aim for increasing their efficiency in completing required tasks in order to increase their available time for engaging in RP. RP should continue to be a focus in training. Even more than talking about the importance of RP, training should include explicit discussion of the difficulties associated with finding time to engage in RP and the possible feelings of distress (anticipatory and resultant). Training should include training in RP with a focus on actively managing any associated distress as well as different

methods for engaging in RP. For example, some methods are shorter and may be easier to integrate into daily practice, such as taking a few minutes after a session and assessing emotional states. Some methods may be a better fit and more useful for certain psychotherapists, such as peer supervision or a reflective journal.

In addition, to ways in which psychotherapists can increase engagement in RP on their own and how psychotherapy training can support RP, institutions may also desire to support engagement in RP among their psychotherapists. Institutions could be thoughtful about the requirements asked of psychotherapists with the aim of allowing sufficient time for psychotherapists to complete required work, engage in the face-to-face work, and engage in essential support work, like honing therapeutic skills and RP. Some institutions may find it useful to require activities that are generally associated with RP, such as case conferences and peer supervision.

Although institutions could require that psychotherapists spend time engaged in RP, other than documenting duration, there are no widely accepted objective measures of RP. When considering the most useful ways to encourage increasing engagement in RP, institutions may find that focusing on increasing the individual psychotherapists' opportunity and desire to engage in RP is less disruptive, time-consuming, and effortful than creating a system that requires and documents engagement in RP. This is particularly true if the system is overly rigid, thus risking becoming another requirement that takes away from engagement in RP, rather than encouraging it.

This study revealed several areas that warrant additional research in order to more fully understand and address the integration of RP into everyday psychotherapy practice. Future investigations would benefit from several elements, including a longitudinal

design to examine how engagement in RP changes over time, and assessment of potential variables that affect those changes (e.g., EA, clinical setting, theoretical orientation). An intervention study that directly addresses EA could document changes in RP as EA is decreased, thus further illuminating the impact of EA on RP. The addition of a semi-structured interview could expand on the current qualitative findings by digging deeper into how participants prioritize their time by actively supporting their articulation of the relative importance of different tasks.

Several quantitative measures, indicated by the current results, could be added to increase the depth of current knowledge about RP. For example, measures of dissociation, state-trait anxiety, and the evaluation of whether psychotherapists tend towards EA or RP in response to distress would allow for a clearer articulation of the impact of EA on RP. To further quantify the role of institutional factors in engagement in RP, it would be useful to know more about the time participants spend occupied in required activities. Institutions may also benefit from a clearer understanding of what, if any, role the layout of a workplace has on fostering collegiate relationships that support engagement in RP. For example, as suggested by the qualitative results, it is possible that an increase in informal spaces that promote regular interaction among psychotherapists would increase their feelings of trust and willingness to engage in RP with each other.

Limitations

This study showed novel findings on psychotherapist attitudes towards RP and initial articulation of factors that impact engagement in RP; however, it is not without its limitations. A lack of specificity in the measures, such that they were not measuring the complex concepts accurately, may have impacted the detectability of some effects. For

example, measuring time spent in RP is challenging because of the number of forms it takes. It is possible that the participants did not uniformly respond to the questions that were the basis for the RPR. For example, some participants may not have fully accounted for some of their time spent in RP because they did not include such practices as informal peer consultation. A mixed-methodology that included a semi-structured interview could elucidate the full range of RP activities in which participants engage. Similarly, EA is complex concept that can take a variety of forms and includes a range of related concepts (as evidenced by the subscales of the MEAQ). One of the main strengths of the MEAQ is the ability to use the subscales to compare the differentiated processes involved with EA. In addition, the online survey format did not allow participants to ask questions about the prompts prior to responding. This may also have impacted the detectability of some effects.

Given that participants, as trained psychotherapists, were likely aware of the desirability of engaging in RP, social desirability may have impacted their responses, resulting in overestimations of reported RP. Even so, a range of RP time was reported. In addition, the range was sufficiently wide that the sample was divisible into high RP and low RP groups. For comparing groups, as was done here, the reported time engaged in RP, even if inflated, is less important than the difference between the groups.

Finally, RP and clinical practice are complex entities with many influences and this study focused narrowly on a few key variables. As a largely correlational study, causal relationships between variables cannot be assessed. Moreover, several additional variables are also possibly impacting engagement in RP. Thus, it is possible that one or more of these variables could play a mediating or moderating role in the relationship

between EA and RP. Future research can expand the model of RP and clinical practice by including these variables.

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Appendix A: Recruitment Material

For distributing on listservs and to colleagues

Dear Colleagues,

I am writing to invite you to participate in a study of psychotherapists. We are interested in some of the activities you engage in to support your psychotherapy practice and the factors that either support or prove to be barriers. Towards this effort, we are asking independently licensed psychotherapists who engage in at least one hour a week of psychotherapy to respond to a brief survey (about 30 minutes). The survey asks you to describe your current practice and orientation, some of the things you do to support your psychotherapy practice, and how you process thoughts and feelings. Upon completion of participation, you will be offered a choice of compensation options: 1) a chance to win one of three $100 giftcard to Amazon.com or 2) free 1.5 CE course from tzkseminars.com.

www.tinyurl.com/surveyPEP

This study is approved by the Suffolk University IRB (Protocol #) and is part of my dissertation work. Matt Jerram, Ph.D., is the dissertation chair and the study's investigator. We will not be collecting identifying information for data analysis or participant tracking. Any identifying information provided for the purposes of compensating you for your time will be destroyed as soon as possible. Please keep in mind that, since no identifying information will be kept for data analysis, no one will be able to connect you with your responses on the survey.

Thank you for considering contributing to this research.

Alison Thomas, M.A.
arthomas2@suffolk.edu

For distribution to clinic directors

Dear _____,

I am writing to ask that you distribute the following letter to any independent psychotherapists who work in your clinic. It invites them to participate in a research study. We are hoping to better understand the activities they engage in to support their psychotherapy practice and the factors that either support or prove to be barriers. This study is approved by the Suffolk University IRB (Protocol #) and is part of my dissertation work. Matt Jerram, Ph.D., is the dissertation chair and the study's principal investigator.

Thank you for your consideration.

Warmly,
Alison Thomas, M.A.
arthomas2@suffolk.edu

Facebook Post
Here's an opportunity to participate in research about being a psychotherapist, it takes less than 30 min. www.tinyurl.com/surveyPEP

Appendix B: Professional Experiences and Practice Survey

Study Information & Informed Consent

Thank you for taking the time to consider participating in a study aimed at better understanding psychotherapists' practice. This study is formatted so that it can also be completed on hand-held devices, like a phone. This study is approved by the Suffolk University IRB (protocol # **729520**).

We are exploring aspects of psychotherapists' experiences with how they use their time outside of the therapy room to support their practice. Participation is voluntary. If you choose to participate, you will be asked a range of questions about your professional identity (e.g., theoretical orientation, weekly hours of clinical work), how you deal with thoughts and emotions, and some of the things you do outside of the therapy room to support your psychotherapy practice. Some of the questions may cause you psychological discomfort. You can skip any question you wish. We do not expect you to benefit directly from participation; however, the results of this research will contribute to general knowledge. We will not be collecting identifying information for use in our data analysis or participant tracking. Your decision to participate or not will not impact your employment status.

The main portion of this survey should take about 30 minutes. There is an optional open-response section at the end. We would greatly appreciate any thoughts you have the time and inclination to share. To compensate you for your time, we are offering an entry into a raffle for one of three $100 gift cards to Amazon.com or a free 1.5 CE Course at TZKSeminars.com (The "All-or-Nothing" phenomenon in Borderline Personality Disorder). We will be recruiting up to 150 participants. We anticipate that at least 100 participants will enter the raffle which would mean an approximate 1 in 33 chance of winning. TZKSeminars is a company started by a clinical psychologist who aims to provide fellow practitioners with high quality trainings that are affordable and convenient. Courses are available as live webinars or recordings of webinars than can be accessed at any time and are presented by experts in the content area.

At the end of the survey is information about how to submit your responses and space for you to provide an email address to receive the compensation of your choice. This email address will not be connected to your responses to the survey and all email addresses will be discarded after distribution of compensation. If you choose the raffle, your email address will be kept until the raffle occurs after data collection is completed. If you choose the CE course, your email address will be kept only until the code to receive your free course has been sent to you.

If you have any concerns or questions, please contact the study's principal investigator, Matthew Jerram, Ph.D., at 41 Temple Street, Dept. of Psychology, 6th Floor, Boston, MA 02114.

General Demographics

1. How old are you? _____ years

2. In terms of gender, how do you identify? e.g., female, cisgender, male
_____

3. Do you practice in the USA? ___ yes ___ no

   a. If no, in what country do you practice? _____

   b. If yes, in which state(s) are you licensed?
   _____

Psychotherapy Practice Demographics

4. Including clinical training, for how long have you been practicing psychotherapy? _____ years

5. Please indicate the top three orientations that influence your current psychotherapy approach and rank them from most to least influential (1 = most influential).

___ Behavioral
___ Cognitive
___ Existential
___ Humanistic
___ Interpersonal
___ Psychodynamic
___ Systemic/Family Systems
___ other

6. To what extent do you consider your psychotherapy approach integrative (integration of elements from multiple orientations in the treatment of psychopathology)? select one response

___ Not at all
___ A bit
___ Somewhat
___ Mostly
___ Primarily

7. Please list any degrees, professional certifications, and specialization you have attained or are in the process of attaining.
e.g., Masters in Clinical Psychology, intensive ACT workshop, Licensed Independent Social Worker

8. For clinical psychologists, is your training based on the Vail (practitioner-scholar, most Psy.D. programs) or Boulder (scientist-practitioner, most Ph.D. programs) model?

___ Vail ___ Boulder ___ unknown

9. On average, how many hours a week do you engage in professional work or activity? _____ hours
e.g., assessment, case management, psychotherapy

10. On average, how many hours a week do you engage in some form of psychotherapy practice? _____ hours
e.g., individual, group, or family therapy

11. In which clinical setting do you spend most of your psychotherapy practice time?

___ independent private practice
___ group private practice
___ hospital in-patient
___ hospital out-patient
___ partial programs
___ residential program
___ community mental health
___ research clinic
___ other: _____

12. How many cases are on your current caseload? _____

13. How much control do you have over how you use your time? (i.e., How large is your role in determining the make-up of your clinical hours?) check one

___ none
___ barely any
___ some
___ quite a bit
___ a lot
___ complete

Practice Questions

In this survey, reflective practice (RP) refers to the process of reflecting upon a particular aspect of one's own activity in order to better understand that activity and the impact of one's personal predisposition (e.g., beliefs, history, biases) on that activity.

For example, you may take some time to consider whether or not they applied a psychotherapy technique to its maximum effectiveness. You could also consider whether or not your personal history is affecting their understanding of clients (e.g., having a personal history of a parent with alcoholism could affect how you perceive a client struggling with alcoholism). Additionally, you could consider how clients' current behavior is bringing them into conflict with their environment (i.e., case conceptualization). All of these instances are examples of reflective practice – they differ in terms of the aspect of practice on which the reflection focuses. Reflective practice can take on many forms, such as supervision, consultation groups, personal therapy, and journaling.

Please answer the following questions to the best of your ability. Keep in mind that although there are multiple forms of clinical practice, these questions refer specifically to psychotherapy. Please also note that we understand that there is often a considerable gap between how we would like to practice and how we must practice. We are investigating what, if any, gap exists and the factors that impact how close to our ideal we are able to

practice. We are also very aware that the value placed on reflective practice varies across individuals, orientations, professions, and a variety of other factors. Our intention is to better understand these aspects of practice.

14. In which of the following activities do you regularly engage? (please check all that apply)

___ peer supervision/consultation

___ group supervision/consultation group

___ process notes

___ private written reflection (e.g., diary)

___ treatment team meeting

___ private thought/reflection

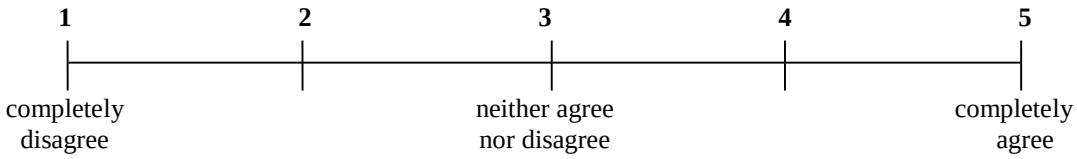
___ mindfulness

___ other

15. If you choose to engage in RP, what is your preferred format?
e.g., peer consultation, diary, private thought

16. In what activities related to RP are you required to engage due to your professional or workplace requirements?
e.g., individual supervision, process notes, team meeting

Please rate the extent to which you agree with each of the following statements using the scale provided.



17. Reflective practice is a valuable component of psychotherapy practice. _____

18. Reflective practice takes time away from the work I need to get done. _____

19. Psychotherapists should be required to engage in reflective practice. _____

20. Reflective practice is an essential element of my psychotherapy practice. _____

21. Many things a psychotherapist needs to take care of are more important than reflective practice. ____

22. I make reflective practice a priority. _____

23. **Ideally**, how much time in a week would you **prefer** to spend reflecting on some aspect of your psychotherapy practice? _____

24. On average, how much time in a week do you **actually** spend reflecting on some aspect of your psychotherapy practice?_____

25. **Ideally**, of the time reported in question 24, please give your **preferences** for what percentage of that time would be spent focused on each of the following areas.

a. What your clients bring to psychotherapy (e.g., case conceptualization): _____%

b. What to do in psychotherapy (e.g., treatment planning, risk management): _____%

c. What you bring to psychotherapy (e.g., personal beliefs, biases): _____ %

d. Reactions that come up in response to what happens in psychotherapy (e.g., feeling frustrated with a client): _____ %

26. Of the time reported in question 24, please give your best estimate for what percentage of that time is **actually** spent focused on each of the following areas.

a. What your clients bring to psychotherapy (e.g., case conceptualization): _____%

b. What to do in psychotherapy (e.g., treatment planning, risk management): _____%

c. What you bring to psychotherapy (e.g., personal beliefs, biases): _____ %

d. Reactions that come up in response to what happens in psychotherapy (e.g., feeling frustrated with a client): _____ %

For the next two questions, please focus on reflective practice in which you consider what you bring in to the therapy room and your reactions to psychotherapy (parts c & d from the previous question).

27. Please list the factors that make you **more likely** to engage in reflective practice.

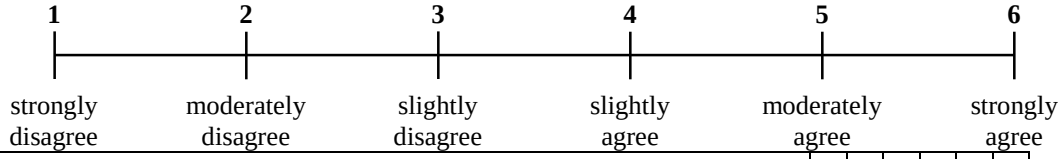
e.g., workplace factors, personal beliefs, critical incident, peer support, surprising reaction to a client

28. Please list the factors that make you **less likely** to engage in reflective practice.

e.g., relationship with colleagues, personal beliefs, lack of resources, workplace factors

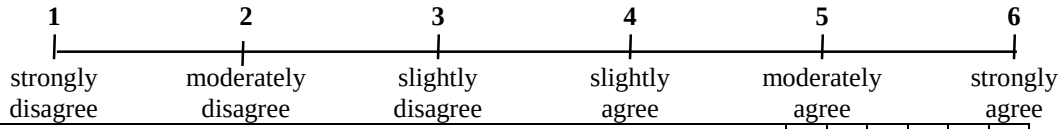
Dealing with Thoughts and Feelings

Using the following scale, please indicate the extent to which you agree or disagree with each of the following statements.



#	item	1	2	3	4	5	6
29	I won't do something if I think it will make me uncomfortable.						
30	If I could magically remove all of my painful memories, I would.						
31	When something upsetting comes up, I try very hard to stop thinking about it.						
32	I sometimes have difficulty identifying how I feel.						
33	I tend to put off unpleasant things that need to get done.						
34	People should face their fears.						
35	Happiness means never feeling any pain or disappointment.						
36	I avoid activities if there is even a small possibility of getting hurt.						
37	When negative thoughts come up, I try to fill my head with something else.						
38	At times, people have told me I'm in denial.						
39	I sometimes procrastinate to avoid facing challenges.						
40	Even when I feel uncomfortable, I don't give up working toward things I value.						
41	When I am hurting, I would do anything to feel better.						
42	I rarely do something if there is a chance that it will upset me.						
43	I usually try to distract myself when I feel something painful.						
44	I am able to "turn off" my emotions when I don't want to feel.						
45	When I have something important to do I find myself doing a lot of other things instead.						
46	I am willing to put up with pain and discomfort to get what I want.						
47	Happiness involves getting rid of negative thoughts.						
48	I work hard to avoid situations that might bring up unpleasant thoughts and feelings in me.						
49	I don't realize I'm anxious until other people tell me.						
50	When upsetting memories come up, I try to focus on other things.						
51	I am in touch with my emotions.						
52	I am willing to suffer for the things that matter to me.						
53	One of my big goals is to be free from painful emotions.						
54	I prefer to stick to what I am comfortable with, rather than try new activities.						
55	I work hard to keep out upsetting feelings.						
56	People have said that I don't own up to my problems.						

Dealing with Thoughts and Feelings (cont.)



#	item	1	2	3	4	5	6
57	Fear or anxiety won't stop me from doing something important.						
58	I try to deal with problems right away.						
59	I'd do anything to feel less stressed.						
60	If I have doubts about doing something, I just won't do it.						
61	When unpleasant memories come to me, I try to put them out of my mind.						
62	In this day and age people should not have to suffer.						
63	Others have told me that I suppress my feelings.						
64	I try to put off unpleasant tasks for as long as possible.						
65	When I am hurting, I still do what needs to be done.						
66	My life would be great if I never felt anxious.						
67	If I am starting to feel trapped, I leave the situation immediately.						
68	When a negative thought comes up, I immediately try to think of something else.						
69	It's hard for me to know what I'm feeling.						
70	I won't do something until I absolutely have to.						
71	I don't let pain and discomfort stop me from getting what I want.						
72	I would give up a lot not to feel bad.						
73	I go out of my way to avoid uncomfortable situations.						
74	I can numb my feelings when they are too intense.						
75	Why do today what you can put off until tomorrow.						
76	I am willing to put up with sadness to get what I want.						
77	Some people have told me that I "hide my head in the sand."						
78	Pain always leads to suffering.						
79	If I am in a slightly uncomfortable situation, I try to leave right away.						
80	It takes me awhile to realize when I'm feeling bad.						
81	I continue working toward my goals even if I have doubts.						
82	I wish I could get rid of all of my negative emotions.						
83	I avoid situations if there is a chance that I'll feel nervous.						
84	I feel disconnected from my emotions.						
85	I don't let gloomy thoughts stop me from doing what I want.						
86	The key to a good life is never feeling any pain.						
87	I'm quick to leave any situation that makes me feel uneasy.						
88	People have told me that I'm not aware of my problems.						
89	I hope to live without any sadness and disappointment.						
90	When working on something important, I won't quit even if things get difficult.						

Thank you for your time.

Please use this space to share any thoughts you have the time and inclination to share.

Compensation options are on the next page.

We are excited to offer you several choices to compensate you for your time. Please review the options and indicate your selection. We will contact you shortly after your submission with the details on how to access your compensation. We will endeavor to respond to you as quickly as possible.

1. The All-or-None Phenomenon in Borderline Personality Disorder
presented by Keith Hannan, PhD at TZKSeminars.com
1.5 CE's, $29 value

2. One 1 CE course from a selection of 10 courses
at CE-credit.com

3. Chance to win one of three $100 giftcards to Amazon.com

Appendix C: Codebook

VARIABLE	SPSS VARIABLE NAME	CODING
identification number	id	
data complete	complete	1 = yes 2 = no
research consent	consent	1 = yes 2 = no
participant age	age	
participant gender	gender	1 = female 2 = male
practice in the USA?	usa	1 = yes 2 = no
first state of licensure	state1	
second state of licensure	state2	
country of licensure, if not USA	country	
years of practice	yop	
influential orientations: behavioral	beh	0 = not in top three most influential 1 = first most influential 2 = second most influential 3 = third most influential
influential orientations: cognitive	cog	0 = not in top three most influential 1 = first most influential 2 = second most influential 3 = third most influential
influential orientations: existential	exist	0 = not in top three most influential 1 = first most influential 2 = second most influential 3 = third most influential
influential orientations: humanistic	human	0 = not in top three most influential 1 = first most influential 2 = second most influential 3 = third most influential
influential orientations: interpersonal	interper	0 = not in top three most influential 1 = first most influential 2 = second most influential 3 = third most influential
influential orientations: psychodynamic	psychodyn	0 = not in top three most influential 1 = first most influential 2 = second most influential 3 = third most influential
influential orientations: systems/family systems	systems	0 = not in top three most influential 1 = first most influential 2 = second most influential 3 = third most influential

influential orientations: other	otherorientation	0 = not in top three most influential 1 = first most influential 2 = second most influential 3 = third most influential
influential orientations: text-other	otherorienttext	0 = not in top three most influential 1 = first most influential 2 = second most influential 3 = third most influential
extent of integrative approach in psychotherapy	integrative	1 = not at all 2 = a bit 3 = somewhat 4 = mostly 5 = primarily
participant degree	degree	1 = PhD, PsyD, MD 2 = MA, MS, MSW, LICSW, LCSW 3 = other
# of hours a week spent engaged in professional activity	Profhrs	
# of hours a week spent engaged in clinical activity (i.e., psychotherapy)	clinhrs	
Primary clinical setting: private practice	private	0 = no 1 = yes
Primary clinical setting: group practice	group	0 = no 1 = yes
Primary clinical setting: inpatient clinic	inpt	0 = no 1 = yes
Primary clinical setting: outpatient clinic	outpt	0 = no 1 = yes
Primary clinical setting: partial hospital	partial	0 = no 1 = yes
Primary clinical setting: residential program	resident	0 = no 1 = yes
Primary clinical setting: community mental health	cmh	0 = no 1 = yes
Primary clinical setting: research clinic	research	0 = no 1 = yes
Primary clinical setting: clinical setting other	clinsetother	0 = no 1 = yes
Participant caseload	caseload	
Perceived degree of control over distribution of clinical time	control	1 = none 2 = barely any 3 = some 4 = quite a bit 5 = a lot 6 = complete

Reflective practice activity: peer supervision/consultation	peersup	0 = no 1 = yes
Reflective practice activity: group supervision/consultation group	grpcnslt	0 = no 1 = yes
Reflective practice activity: process notes	pronotes	0 = no 1 = yes
Reflective practice activity: private written reflection	diary	0 = no 1 = yes
Reflective practice activity: treatment team meeting	team	0 = no 1 = yes
Reflective practice activity: private thought/reflection	thought	0 = no 1 = yes
Reflective practice activity: mindfulness/meditation	mfness	0 = no 1 = yes
Reflective practice activity: other activities	actother	0 = no 1 = yes
Rating on values statement 1	value1	0 = completely disagree 1 2 = neither agree nor disagree 3 4 = completely agree
Rating on values statement 2	value2	0 = completely disagree 1 2 = neither agree nor disagree 3 4 = completely agree
Rating on values statement 3	value3	0 = completely disagree 1 2 = neither agree nor disagree 3 4 = completely agree
Rating on values statement 4	value4	0 = completely disagree 1 2 = neither agree nor disagree 3 4 = completely agree
Rating on values statement 5	value5	0 = completely disagree 1 2 = neither agree nor disagree 3 4 = completely agree
Rating on values statement 6	value6	0 = completely disagree 1 2 = neither agree nor disagree 3 4 = completely agree

ideal amount of time for RP per week (in min)	rptimeideal	
actual amount of time for RP per week (in min)	rptimeactual	
Ideal % of RP time focused on what the ct brings in (case conceptualization)	caseideal	
Ideal % of RP time focused on what to do (tx planning)	txplanideal	
Ideal % of RP time focused on what therapist brings in (personal biases/history/opin)	personalideal	
Ideal % of RP time focused on therapist's reactions to session	reactideal	
Actual % of RP time focused on what the ct brings in (case conceptualization)	caseactual	
Actual % of RP time focused on what to do (tx planning)	txplanactual	
Actual % of RP time focused on what therapist brings in (personal biases/history/opin)	personalactual*	
Actual % of RP time focused on therapist's reactions to session	reactactual*	
personalactual % as an integer	personalper*	
reactactual % as an integer	reactper*	
RP introspective time % as an integer	introper*	
Time spent in introspective RP (min)	introtime*	
Reflective Practice Ration = clinical time (min)/introtime	RPR	
MEAQ questions 01-62	MEAQ01 - MEAQ62	1 = strongly disagree 2 = moderately disagree 3 = slightly disagree 4 = slightly agree 5 = moderately agree 6 = strongly agree
MEAQ reverse scored questions (23 & 30)	MEAQ23r & MEAQ30r	
MEAQ Behavioral Avoidance Subscale	MEAQBA	
MEAQ Distress Aversion Subscale	MEAQDA	
MEAQ Procrastination Subscale	MEAQPro	
MEAQ Distraction and Suppression Subscale	MEAQDS	
MEAQ Repression and Denial Subscale	MEAQRD	
MEAQ Distress Endurance Subscale	MEAQDE	
MEAQ Total Score	MEAQtotal	

PHLMS Questions 01-20	PHLMS01 - PHLMS20	1 = never (experienced in the past week) 2 = rarely 3 = sometimes 4 = often 5 = very often
PHLMS Awareness Subscale	PHLMSaware	
PHLMS Acceptance Subscale	PHLMSaccept	
PHLMS Total score	PHLMStotal	
FS Questions 1-8	FS1 – FS 8	1 = strongly disagree 2 = disagree 3 = slightly disagree 4 = neither agree nor disagree 5 = slightly agree 6 = agree 7 = strongly agree
FS Total score	FStotal	
Personalactual as a decimal	personalper	
Reactactual as a decimal	reactper	
Percent of reflective time spent with introspective focus	introper	
Time in minutes spent with introspective focus	introtime	
Reflective Practice Ratio (clinhrs/introtime)	rpr	

*variables that are required for calculating RPR